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Ontario

ROYAL COMMISSION OF INQUIRY INTO CERTAIN
DEATHS AT THE HOSPITAL FOR SICK CHILDREN AND
RELATED MATTERS.

Hearing held
8th floor
180 Dundas Street West
Toronto, Ontario

The Honourable Mr. Justice S.G.M. Grange

Commissioner

P.S.A. Lamek, Q.C.

Counsel

E.A. Cronk

Associate Counsel

Thomas Millar

Administrator

Transcript of evidence
for

February 28, 1984

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180 Dundas Street West, Toronto,
Ontario, on Tuesday, the 28th
day of February, 1984.

- - - -

THE HONOURABLE MR. JUSTICE S.G.M. GRANGE - Commissioner
THOMAS MILLAR - Administrator
MURRAY R. ELLIOT - Registrar

- - - -

APPEARANCES:

E. CRONK	Commission Counsel
D. HUNT	Counsel for the Attorney
L. CECCHETTO	General and Solicitor General
	of Ontario (Crown Attorneys
	and Coroner's Office)
I. G. SCOTT, Q.C.)	Counsel for The Hospital for
I. J. ROLAND)	Sick Children
R. BATTY)	
B. PERCIVAL, Q.C.)	Counsel for The Metropolitan
D. YOUNG)	Toronto Police
K. CHOWN	Counsel for numerous Doctors
	at The Hospital for Sick
	Children
E. McINTYRE	Counsel for the Registered
	Nurses' Association of Ontario
	and 35 Registered Nurses at
	The Hospital for Sick Children


(Cont'd)



APPEARANCES (CONTINUED)

D. BROWN	Counsel for Susan Nelles - Nurse
E. FORSTER	Counsel for Phyllis Trayner - Nurse
M. ROSENBERG	Counsel for Sui Scott - Nurse
J. A. OLAH	Counsel for Janet Brownless - R.N.A.
B. JACKMAN	Counsel for Mrs. M. Christie - R.N.A.
S. LABOW	Counsel for Mr. & Mrs. Gosselin, Mr. & Mrs. Gionas, Mr. & Mrs. Inwood, Mr. & Mrs. Turner, Mr. & Mrs. Lutes, and Mr. & Mrs. Murphy (parents of deceased children)
W. W. TOBIAS	Counsel for Mr. & Mrs. Hines (parents of deceased child Jordan Hines)

VOLUME 111



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I N D E X O F W I T N E S S E S

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--- Upon commencing at 10:00 a.m.

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THE COMMISSIONER: I am going to make a few statements Mrs. Radojewski, so if you would like to sit down in the body of the Court we will call you back at the appropriate time.

I have several things I want to say before we get started this morning. The first one is on the evidentiary problems between Phase 1 and Phase 2. There are two main tasks before this Commission; the first is to determine how some 36 babies who died at the Hospital for Sick Children came to their deaths. The second is the consideration of the police investigation and the prosecution of Susan Nelles for murder in relation to four of those deaths.

At the beginning of the Inquiry we decided to proceed with each of the two main issues in a separate phase, that is we would take the evidence on the cause of death first and after the completion of that Inquiry move on to the police investigation as a separate phase of the Commission. I emphasize that the procedure was adopted for convenience only; there is nothing in the Order in Council or anywhere else prescribing any particular order. The procedure was followed for many months without incident. The dividing line was sometimes very very difficult to draw, but



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2 any evidence that was relevant only to stage 2 was
3 excluded. Recently, however, as we approach the end
4 of Phase 1 and certain nurses have been testifying,
5 it seemed more convenient to permit Phase 2 questions
6 to be asked and thus save the recalling of a witness
7 during Phase 2 for perhaps only one or two questions.
8 It was intended to serve the convenience not only of
9 the Commission but of the witnesses as well.

10 The change has, in one respect, not
11 worked well as a simple example will readily demonstrate.
12 A witness, a nurse, is asked, assuming that some person
13 contributed to the deaths, whether at the time of
14 Susan Nelles' arrest she (the witness) thought Susan
15 Nelles or some other person was the more reasonable
16 suspect. The answer to that question is quite worth-
17 less on the resolution of Phase 1, although the facts
18 upon which the opinion is based might be valuable, but
19 the very opinion itself might be helpful upon Phase 2.
20 If, for instance, there was an opinion held which was
21 or was not communicated to the police it might have
22 affected their investigation. I do not say that it
23 would necessarily, and I do not want to prejudge the
24 matter. I say only that in fairness to the police it
25 seems to me their Counsel had the right to go into it
in Phase 2.



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2 The difficulty in the new procedure
3 stems from the fact that this is a very public Inquiry.
4 The media and the public cannot distinguish the
5 subtle distinction in relevance and perhaps we should
6 never have expected them to be able to do so. The
7 result is that evidence which is relevant only to
8 Phase 2 is taken as evidence as to the complicity of
9 the person named. That is most unfortunate because it
10 is neither the purpose nor the result of the evidence
11 so far as the Commission is concerned.

12 Because of the difficulty I think it is
13 best to revert to the original plan. Henceforth
14 there will be no Phase 2 only questions allowed
15 until we reach that phase. It is my hope that we
16 will thereby solve the problem at least for the
17 immediate future. When we come to Phase 2 the
18 problem may arise again. At that time, if the evi-
19 dence is to be received, we will have to consider
20 whether the public conception of the purpose of the
21 evidence is such that it can be safely and publicly
22 tendered; if not, we will have to seek some other
23 solution, bearing in mind as I always have to do the
24 conflicting interests of the parties. I regret the
25 inconvenience it will cause the witnesses and the
possible delay for the Commission, but for the
reasons that I have given I feel compelled to
make the Order and I would ask all Counsel to



1
2 co-operate.

3 Now, the second matter that I want to
4 deal with is the ruling on the application of Counsel
5 for the parents to examine statements made to the
6 police. This is a motion brought by Counsel for the
7 parents seeking to examine certain statements of
8 persons made to the Metropolitan Toronto Police in the
9 course of their investigation. A somewhat related
10 motion was made earlier at the hearing, and a ruling
11 made, so I do not need to go too deeply into the
12 details.

13 It is sufficient to say that in the
14 course of their investigation the police took many
15 statements from and made voluminous notes of antici-
16 pated evidence of numerous persons who were in any
17 way associated with the care of the babies whose
18 deaths we are now investigating. Commission Counsel
19 has examined and re-examined all these documents in
20 order to determine what persons could give useful
21 testimony in the cause of death of the children.

22 Commission Counsel have called many witnesses on that
23 issue and it is hoped to have completed all the
24 evidence thereon by or shortly after the end of March.
25 At that time other Counsel will be invited to make
representations as to the calling of evidence not



1
2 called by Commission Counsel. In preparation for that
3 day Counsel for the parents now wish to examine all of
4 the documents relating to the interviews undertaken by
5 the police with certain named persons. Of the 10
6 children whose parents are represented at the hearing
7 I am told there are over one hundred files of documents.
8 Some of the files relate to persons who have already
9 testified without any reference to the statements; some
10 of the files relate to persons for whom no statements
11 exist; some of those named will in due course testify
12 at the behest of the Commission, but the majority of
13 the files relate to persons who have not testified and
14 in the ordinary course will not be called.

15 The first aim is to examine these
16 documents to determine if there is anything there that
17 might be relevant to the cause of death of a particular
18 child. If so Counsel for the parents will approach
19 Commission Counsel to call that particular witness. If
20 that request is unsuccessful they will approach me to
21 issue a subpoena.

22 The previous motion that I referred to
23 earlier came about because one witness who had been
24 testifying was revealed to have given a statement to
25 the police and that had been provided to some but not
all Counsel. The police were then, as now, happy to



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2 provide the statement to anyone if that witness
3 consented, that consent was not forthcoming.

4 As I pointed out in my Reasons on the
5 previous motion, the practice of Commission Counsel is
6 to give to all potential witnesses copies of all
7 statements made or attributed to them. It is also
8 their practice to give to the party concerned any
9 statement or part of a statement that might tend to
10 implicate or exculpate that party if it is intended
11 to adduce the subject matter of that statement in
12 evidence. I ruled on that occasion that no statement
13 need be produced until the witness gave testimony.
14 Then, if the witness gave evidence adverse to a party
15 that party would be entitled to see the statement for
16 purposes of cross-examination. I also ruled that there
17 might come a time when many parties having referred to
18 the statement, it would become unfair to withhold it to
19 any. Indeed, in my view, that state had been reached
20 in the case under review.

21 This situation is, however, different.
22 It is an application to see the statements not for the
23 purpose of cross-examination of a witness who is
24 testifying, but for the purpose of seeing whether the
25 person should become a witness. I can well understand
the reluctance of Counsel for the parents to having



1
2 someone else determine the evidence that will be
3 presented with respect to the children whose parents
4 they represent, but I must nevertheless reject the
5 motion, and I do so for the following reasons:

6 1. The interests of the Commission and
7 the parents are identical. The parents have a more
8 particular interest in the death of a particular child
9 and can and do sometimes cast some light upon the cause
10 of that death that might otherwise have been missed.
11 It is unlikely that after Commission Counsel has decided
12 that the evidence of a particular person is not helpful
13 any prejudice will result to the interests of the
14 parents. Counsel for the Commission will keep these
15 statements under constant review and will call any
16 witness whose evidence formerly rejected becomes
17 material.

18 2. On the other hand, the prejudice to
19 other persons of the contents of these documents should
20 become public is incalculable. I do not of course
21 mean legal prejudice for this is a public inquiry which
22 has evoked much media coverage. Many of these statements
23 contain totally unfounded allegations and speculations
24 which are useless as evidence and could be very
25 damaging to reputations. I appreciate that Counsel for
the parents have undertaken not to disclose the contents



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2 of the documents even to their clients. Even if that
3 were practical, I doubt that an order can go for
4 inspection by any Counsel without inspection by all,
5 the more eyes that have seen the document the harder
6 it will be to keep its contents secret.

7 3. I think that effect should be given
8 to the position of the police. The people they
9 interviewed would of necessity have realized that the
10 information they gave might be used in the investi-
11 gation and in any prosecution arising out of it, where
12 it would be used with discretion. They would not
13 expect that the information given in confidence would
14 be passed indiscriminately by any counsel who appeared
15 before a commission of inquiry.

16 4. The proposal of inspection has many
17 of the features of an examination for discovery. A
18 commission of inquiry should not be conducted so as to
19 give discovery to all parties with standing. Section
20 5-1 of the Public Enquiries Act requires the Commission
21 to give to every person having a substantial and direct
22 interest opportunity to give evidence and to call
23 witnesses on evidence relevant to his interest. It
24 does not afford him the benefit of the discovery
25 process. I do not think that benefit was ever
contemplated.



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The motion was brought with the highest motives and in the interests of their clients, and the dangers of abuse and delay to the proceedings are inherent. For all these reasons I dismiss the motion.

Now the third thing, Mr. Roland, I believe you have something you want to say.

MR. ROLAND: Yes sir. I would like to say a few words to put in perspective the evidence we have heard so far from nurse witnesses. As you know, a great deal of attention has been brought to bear on the many nurses and nursing assistants associated with the Cardiology Ward of the Hospital for Sick Children. This attention is intense both in the hearing room and in the media and it has left many nurses at the hospital and elsewhere with the sense that nursing staff associated with the Cardiology Ward are being faulted for not detecting some possible wrongdoing prior to March 23rd, 1981; and with the sense that nurses are being blamed for the police arresting Susan Nelles rather than some other person or persons in March of 1981. These matters will be for you to decide.

On behalf of the Hospital for Sick Children we have attempted to assist this Inquiry in its work, so has the staff of the hospital including its doctors and nurses. This especially includes the



1
2 nursing staff members that have testified before you.
3 They have spent long hours reviewing hospital charts
4 and other records. They have co-operated with us and
5 with Commission Staff and its Counsel by attending
6 extensive interview sessions in preparation for
7 testifying before you.

8 Most importantly the nurses at our
9 hospital have continued to demonstrate their
10 professional attitude to their duties and their
11 devotion to the care of very sick children. They have
12 been under extreme stress caused not only by the events
13 leading up to March 1981, but also by all of the
14 events that have followed up to today.

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We wish to emphasize the professional-
ism of the Hospital for Sick Children's Nursing
Staff, their devotion to their duties and their
sincere concern to provide the best nursing care
possible to infants at the Hospital.

We are confident that this Commission
does appreciate the highly professional attitude
taken by the nurses that have come before it and
their unfailing devotion to the children at the
Hospital. Indeed, it is this devotion to duty that
has brought the Hospital through the most troubling
of times since 1981. The professionalism and
unwaivering commitment of the Department of Nursing
at the Hospital for Sick Children to save and
prolong lives is unquestioned and cannot be in doubt.

Thank you, sir.

THE COMMISSIONER: Thank you, Mr.
Roland. I accept everything you have said about
the nurses at the Hospital for Sick Children
generally. Their devotion to duty, their skill
and diligence, their caring attitude for the children
and their concern for the parents have evoked the
admiration of the whole community, and I mean by
that not just Toronto but the whole country.

I say that without reservation of any



1
2 kind but at the same time I must point out that
3 the conduct and reputation of the nurses generally
4 is not the issue at this Commission.

5 As the issues affect the nurses
6 they are two as I see it as follows:

7 (1) Did any nurse or nurses
8 contribute to the deaths of any of the children
9 under investigation, accidentally or otherwise,
10 and that is what we call Phase 1;

11 Secondly, did any nurse or nurses
12 by their conduct inhibit the police investigation,
13 and that is Phase 2.

14 Now, these are legitimate issues.
15 They certainly are not peculiar to the nurses,
16 they apply to anyone else or any other group
17 equally and particularly to those people who are
18 involved in the care of the children.

19 Now, Miss Cronk.

20 MS. CRONK: Thank you, sir. Mrs.
21 Radojewski.

22 ELIZABETH RADOJEWSKI (Resumed)

23 DIRECT EXAMINATION BY MS. CRONK (CONT'D)

24 Q. Good morning, Mrs. Radojewski.

25 A. Good morning.

Q. You will recall yesterday



1
2 afternoon, Mrs. Radojewski, that we discussed,
3 amongst other matters, certain of the medication
4 errors that were reported to have taken place on
5 Wards 4A and 4B during the nine month period of
6 time with which we are concerned. Do you recall
7 that?

8 A. Yes.

9 Q. And as I understood your
10 evidence yesterday I suggested to you that there
11 had been a medication error involving Brian Gage
12 and you responded by indicating that you did not
13 recall that incident. Do you recall that?

14 A. Yes.

15 Q. So that the record is clear,
16 I am showing to you what has already been filed
17 as an exhibit here, Mrs. Radojewski. It is Exhibit
18 308 and it is described as a Patient Incident
19 Report with respect to patient Brian Gage. It
20 appears to bear your signature, is that correct?

21 A. Yes.

22 Q. And am I correct that the
23 error which involved Brian Gage appears to have been
24 one where a dose of digoxin was given to the child
25 as it was ordered to be done at 5:30 in the morning
on September 24th, 1980 but in error the same dose



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was repeated at 9 in the morning on the same morning?

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A. Yes.

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Q. So, he appears simply to have received a repeat dose of digoxin, as we have heard four other patients did in the latter part of October and one at the beginning of November, 1980?

7

A. Yes.

8

Q. Thank you very much.

9

You will recall yesterday, Mrs.

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Radojewski, that the first of the children who died on these wards that we discussed in any detail was Alan Perreault; do you recall that?

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A. Yes.

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Q. All right. I neglected to ask you about one other matter that is of interest with Alan Perreault. I would like to simply refresh your memory as to the basis for it. You will recall that that child died on July 8, 1980 at 1:45 p.m. Do you recall that?

19

A. Yes.

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Q. That would have been in the early afternoon of the 8 hour day shift that you worked that day on Ward 4A?

22

A. Yes.

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Q. And that child was a Ward



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4A patient at the time of his death?

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A. Yes.

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Q. All right. Did you, Mrs.

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Radojewski, at any time on July 8th prior to that
child's death observe anyone administering any

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medication of any kind to him at any time?

7

A. No, I didn't.

8

Q. Did you at any time on that

9

day observe anyone feeding that child again by any

10

method or at any time?

11

A. Not that I recall.

12

Q. All right, thank you.

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Could we turn then to the case of
David Taylor. This child I recognize was a patient
on Ward 4B at the time of his death. He died on
July 25th, 1980. Would you, in the normal course
of events, have had any reason to see the patient,
having regard to the fact that he was on Ward 4B?

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A. I think he was admitted on
the 25th, wasn't he, and died on the 27th.

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Q. You're quite right, I'm
sorry.

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A. Would I have any occasion to
see him?

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Q. Yes.

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A. Not necessarily. I do believe
at that time I was covering as supervisor, if that
was a weekend.

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Q. Well, to help you with that,
it is my understanding, as you have suggested,
that the child died on July 27th, 1980 and that
you worked an 8 hour day on July 26th, but you did
not work on the day following his death, that is,
July 27th. Is that correct?

10

A. That's correct.

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Q. All right. Just to check the
WIN sheets to confirm that, July 26th was a
Saturday and you were working that day?

14

A. Yes.

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Q. All right. Were you working
in your capacity as a nursing supervisor for that
and other wards?

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A. Yes, I was.

18

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Q. And Sunday, July 27th, did you
work that day?

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A. No, I was off.

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Q. How is it that you would work
one of the two days as a nursing supervisor but not
the second day?

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A. It's possible that I was doing



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a favour for a friend and switched part of a weekend for her.

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Q. All right. Well, while you were in the Hospital on Saturday the 26th of July and when you were making your rounds as nursing supervisor, do you recall having seen David Taylor?

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A. No, I don't recall.

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Q. Could I ask you to turn if you would, and perhaps Mr. Registrar you could provide it again to Mrs. Radojewski the tour end reports, Exhibit 360. I take it however, Mrs. Radojewski, although you don't recall having seen the child it would be fair of me to suggest that you would have necessarily done so when you made rounds that day?

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A. Yes, it's possible I did. I'm sure I did on nursing rounds.

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Q. Thank you. Could I ask you to turn if you would please to page 10 of the tour end report, which is the report dealing with July 25th. It is two days before the child died. That is also the day in which the child was admitted. He is listed on the tour end report for July 25th. Would I correctly suggest that he would be listed automatically that day because it was the day upon



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which he was in fact admitted to the ward?

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A. Yes, and because he was transferred from another hospital.

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Q. And if you would turn if you would please to the tour end report for the very next day, July 26th, that's at page 11. It appears that the only entries with respect to David Taylor are on the back of the page.

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A. Yes.

Q. Do you have that?

A. Yes.

Q. And if we look to the entries on the immediate left-hand side of the page those correspond to the entries made by the day staff on July 26th; on the back of page 11.

A. The complete entry by the day staff?

Q. Yes. I am sorry, there appears to be three columns of information on the back of the page. It is the first column on the left is it not that would have been made by the day shift with respect to David Taylor?

A. I'm unsure.

Q. All right.

THE COMMISSIONER: I am sorry, but



Radojewski, dr.ex.
(Cronk)

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did he not die at 2 o'clock in the morning?

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MS. CRONK: Yes, sir, on the 27th.

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So that dealing now with the tour end report for
July 26th.

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THE COMMISSIONER: Oh, I see. Yes,
yes, all right. And you think there are three
columns, do you?

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MS. CRONK: Q. Well, perhaps you
can help us with that, Mrs. Radojewski. If you
would turn if you would please to the front of page
11. Do you have that?

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A. Yes.

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Q. All right. Am I correct that
there are three columns for information with respect
to any particular patient, the first column being
the one on the immediate left corresponds with
entries that might be made during the 8 hour day
shift up to 3 o'clock in the afternoon?

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A. Yes.

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Q. All right. And the second
column applies for the evening shift up to 11
o'clock at night?

A. Yes.

Q. And then finally the third
column applies the long night nursing shift that



Radojewski, dr.ex.
(Cronk)

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would be on duty from 11 o'clock at night until
7 o'clock the next morning to make further entries
with respect to a particular patient if it is
warranted for any reason. Do I have that correctly?

A. Yes.

Q. All right. I had assumed, and
you can tell me if I am incorrect, that if we turn
to the back of the page and see information recorded,
and sometimes it does not appear to be this way,
but where it does appear to be in one or more
different columns that the entries would reflect
the entries made during the day shift, the evening
shift or the night shift. As a general proposition,
is that the correct way to be interpreting these
tour end reports?

A. Generally, yes.



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Q. And in this particular case, however, you said you can't tell whether the entries on the back of the tour end report for July 26th were made during the day shift or later. Do I have that correctly?

A. That is right.

Q. Well, apart from the recording of the child's death which we note on the back of the page, would it be fair of me to suggest, first of all, that the child appears to have been scheduled for a catheter procedure on the Monday following the Saturday?

A. I think that is what it says, yes.

Q. All right. Would you agree with me further that again apart from the recording of his death there is nothing shown on the tour end report which suggests that that child was regarded by the nursing staff as being critically ill.

A. That is right.

Q. All right. And certainly as a nursing supervisor on the wards that weekend, that Saturday there would be nothing in the tour end report to put you on notice that that child may have



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2
3 been at imminent risk of death or was regarded as
4 being in a grave condition? Is that fair?

5 A. That's fair.

6 Q. All right. You have told us
7 that you did work the Saturday but not the Sunday.
8 It is my understanding you did not work the Monday
9 but you did then come back into the hospital on
10 Tuesday, the 29th of July.

11 A. Yes.

12 Q. Is that right? Do you recall
13 when you returned to the hospital on the Tuesday
14 having any discussion with anyone as to the cause of
15 David Taylor's death?

16 A. No, I don't recall having any
17 discussion.

18 Q. Were any concerns expressed to
19 you that day that you can now recall by anyone,
20 be it a member of the nursing staff or a physician
21 associated with the cardiology unit, as to why that
22 child had died?

23 A. Not that day I can't recall.

24 Q. Did you yourself regard his death
25 in light of what you had known on the Saturday,
26 July 26th, as having been unexpected or surprising?

27 A. It was explainable to me by the



1
2 child's heart condition.

3 Q. What did you understand to be
4 the child's heart condition?

5 A. That he had a critical aortic
6 stenosis.

7 Q. Do you have any recollection
8 when you left on the Saturday as having regarded
9 David Taylor as being either in the process of dying
or being at imminent risk of death?

10 A. No, I don't recall that I did.

11 Q. Well, in that context, even
12 knowing what you did about the child's condition,
13 would it be fair to suggest there was an element of
14 surprise about the fact that he died during that long
night shift?

15 A. I suppose that's a fair
16 assumption.

17 Q. Do you recall at any time on that
18 Tuesday or on the days following when you were in the
19 hospital anyone at any time suggesting to you that
20 digoxin toxicity may have contributed to that child's
death?

21 A. Can you repeat that for me,
22 please?

23 Q. I'm sorry. You told us that you
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25



1
2 came back to work on the Tuesday.

3 A. Yes.

4 Q. Which was the 29th.

5 A. Yes.

6 Q. My question was do you recall
7 on that day or on any of the days thereafter while
8 you were at the hospital anyone suggesting to you
9 that digoxin toxicity may have played a part in
that child's death?

10 A. No, I don't recall.

11 Q. Was there a suggestion made
12 either to you or about which you heard at any time
13 that there might have been some drug, be it digoxin
14 or any other drug, involved in that child's death?

15 A. Not that I recall.

16 Q. We have heard in other evidence,
17 Mrs. Radojewski, that a number of morbidity and mortality
18 meetings were held at the Hospital for Sick Children
19 with respect to a number of these deaths. The first
we have heard was held on September 5th, 1980.

20 Were you in attendance at that meet-
21 ing?

22 A. Yes, I was.

23 Q. Do you recall keeping notes
24 at that meeting?
25



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A. I was the recorder at that meeting, yes.

3

4

Q. I am showing to you -- Mr.

5

Registrar, could you show the witness, if you would, please, a copy of Exhibit 46?

6

7

These are a series of notes, Mrs.

8

Radojewski, dated September 5th, 1980. Can you tell me are these the notes that you kept of the mortality meeting on September 5th?

9

10

A. Those are the notes I recorded, yes.

11

12

Q. The Registrar is going to give you a copy.

13

14

Just while you are looking at the notes, Mrs. Radojewski, can you tell me first whether you now have any recollection of anyone at that meeting on September 5th suggesting that digoxin toxicity may have been involved in the death of David Taylor?

15

16

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18

A. By virtue of what I have

19

recorded here there was obviously some suggestion at the meeting in regards to his ECG that there was some ST depression and a question mark dig. toxic.

20

21

22

Q. You are referring to page 11 of

23

your notes and the comments recorded for David Taylor?

24

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A. Yes.

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Q. Apart from what is in the notes, Mrs. Radojewski, do you have any recollection of any one who was in attendance at that meeting suggesting that digoxin toxicity may have been involved in or contributed to this child's death?

A. No.

Q. Do you remember the matter being discussed at all?

A. Obviously something was said or I wouldn't have recorded, but not in relationship to the cause of his death.

Q. All right. Does your memory flow solely from the fact then that there is this mention made of that issue in your notes?

A. Only by virtue of reading the notes.

Q. All right. Do you have any recollection of who raised the matter at the meeting?

A. No, I don't recall.

Q. Do you have any recollection as to the context in which it was raised?

A. No.

Q. Do you have any recollection as to whether or not any discussion ensued once the issue



1

2

was raised amongst those present at the meeting?

3

A. No. There was no discussion.

4

5

Q. To the best of your recollection was that the first time that you had ever heard the suggestion of digoxin toxicity being raised in connection with the death of David Taylor?

6

7

A. Yes.

8

9

10

11

12

Q. Was there, as best as you can recall it, concern at that meeting as to whether or not that drug had in fact contributed to the child's death, and if so, whether further inquiries should be made?

13

14

A. I wasn't left with the impression -- I was not left with the impression that it had any contribution to his death.

15

16

Q. Do you recall Dr. Izukawa being present at that meeting?

17

A. I don't recall.

18

19

20

Q. Do you remember at any time after David Taylor's death discussing with Dr. Izukawa either the cause of the child's death or the circumstances surrounding his death?

21

22

A. No, I don't.

23

24

25

Q. Were you made aware, Mrs. Radojewski, after David had died that Dr. Izukawa had,



1
2 when he was called as the physician on call into
3 the hospital, that he had checked the medication
4 that David Taylor had received and specifically did
5 so to consider whether or not digoxin or any other
6 medication might have contributed to the child's
7 death? Were you aware of that?

8 A. No, I was not.

9 Q. Did any member of the nursing
10 staff mention that to you?

11 A. No.

12 Q. Do you recall any further dis-
13 cussion after the meeting on September 5th by anyone,
14 be it a representative of the nursing or the medical
15 staff in the hospital, concerning the cause of David
16 Taylor's death, and specifically this issue of
17 digoxin intoxication?

18 A. No, I don't recall.

19 Q. And you have told us you did not
20 have the impression at the meeting that digoxin
21 toxicity had contributed to his death. Is that what
22 you told me a few moments ago?

23 A. Yes.

24 Q. Do you have a specific recollection
25 of what your impression was when you left that
meeting?



1
2 A. In regard to the digoxin toxicity?

3 Q. Yes.

4 A. There is a dig. effect which
5 the physicians refer to that you can see on an ECG,
6 and that was my feeling when it was mentioned at
7 the meeting, that this was what they were seeing on
8 the ECG. The ST depression meant that there was a
9 dig. effect.

10 Q. And did that suggest to you that
11 there was a possibility that the child was suffering
12 from toxicity from digoxin?

13 A. Not at a toxic -- no.

14 Q. Can we go this far together,
15 Mrs. Radojewski, based on the entry that is made in
16 your notes: would it be fair of me to suggest that
17 someone at that meeting did raise the possibility of
18 digoxin toxicity with respect to this child's death?

19 A. Yes.

20 Q. And they did so in the context
21 of discussing also apparently his ECG results?

22 A. Yes.

23 Q. Do you recall any other
24 part of the discussion at that meeting concerning
25 digoxin toxicity in David Taylor?

A. No, I do not.



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Q. Thank you.

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The next child who died on Wards 4A/4B, Mrs. Radojewski, was Amber Dawson who died the very next day, on Monday, July 28th. That is before you returned to the hospital as you have told us. She was, however, as I understand it, also a patient on Ward 4A?

A. Yes, she was.

Q. Is that correct?

A. Yes.

Q. And she had been for several days prior to her death?

A. Yes.

Q. Do you recall seeing Amber Dawson when you were on duty on 4A?

A. Yes.

Q. When was the last time that you saw Amber Dawson prior to her death?

A. More than likely I saw her again on nursing rounds when I was acting as supervisor on July 26th.

Q. That is the Saturday?

A. Yes.

Q. Do you recall now what her condition was when you worked that day?



1

11

2

A. Amber looked relatively stable.

3

I can remember her looking relatively stable to me.

4

Q. When you left on that Saturday

5

as the nursing supervisor, did you have any concerns

6

in your own mind at that time that that child was at

7

imminent risk of death, to use the same language I have

8

used before?

9

A. No.

10

Q. Did you consider her to be in

grave condition?

11

A. No.

12

Q. And I gather that when you did

13

return to the hospital on the Tuesday, in addition

14

to learning about David Taylor's death you learned

15

at the same time about Amber Dawson's death?

16

A. Yes.

17

Q. Do you recall any concerns

18

being expressed to you by any member of the nursing

19

staff on that day concerning the death of Amber

Dawson?

20

A. There were concerns raised by

21

the nursing staff, yes. They were extremely upset.

22

Q. Do you recall who raised those

concerns with you?

23

A. Mrs. Trayner and Susan Nelles

24

25



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had raised the concerns. They were extremely upset
over Amber's death.

3

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Q. When did they raise those concerns
with you?

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A. I'm not sure it would have been the next time I saw them, I am not sure of the date.

MS. CRONK: Mr. Registrar, could you show the witness, if you would please, Exhibit 335, the WIN Sheets for 4A.

Q. Could you look first Mrs. Radojewski, please, at the entries for Ward 4A starting on July 27th, the long night shift; do you have that?

A. Yes.

Q. It appears that Mr. Trayner and certain members of her team, including Miss Nelles, Mrs. Scott and Miss Christie were working the night Amber Dawson died?

A. Yes.

Q. On the long night shift?

A. Yes.

Q. And then if we turn to the WIN Sheet entries for the next week, it appears that those four women did not work again until the long night shift on July 30th, is that correct?

A. Yes.

Q. And you worked days - I'm sorry, when they came in on the long night shift,



1
2 do I have it correctly that would have been
3 approximately 7 o'clock in the evening on the
4 30th?

5 A. I am sorry, would you repeat
6 that.

7 Q. When they came in for work
8 on July the 30th, I take it they would have come
9 in at approximately 7 o'clock in the evening?

10 A. Yes.

11 Q. And that would have been after
12 you left the Hospital that day?

13 A. Yes.

14 Q. You did, however, work days,
15 an 8 hour day shift on the 31st of July, and they
16 would then have been, when you came into work,
17 completing their long night shift from the night
18 before?

19 A. Right.

20 Q. That would then be I take it
21 the first time that you would have seen any of those
22 women at the Hospital after the death of Amber
23 Dawson?

24 A. Yes.

25 Q. Do you recall speaking to
either Mrs. Trayner or Miss Nelles in the intervening



1

2

days before the 31st of July?

3

A. Not that I recall.

4

5

Q. Does that help you in any way in determining when it was that Phyllis Trayner and Susan Nelles raised these concerns with you?

6

7

A. It is quite possible it was the morning of the 31st.

8

9

Q. Do you recall now why they appeared to be, as you have suggested, extremely upset over Amber Dawson's death?

10

11

A. They were upset because they couldn't figure out why she had died, they were not getting an adequate explanation.

12

13

14

Q. Did any of the other nurses from Ward 4A/B raise similar concerns with you?

15

16

A. Yes, it was a general feeling.

17

18

Q. Were you at that time able to offer them any explanation as to why Amber had died?

19

20

A. At that time, no.

21

22

Q. I take it that on the basis of the concerns that they raised with you they regarded her death both as unexplained and unexpected given the circumstances?

23

24

A. Yes.

25

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Q. What did you do as a result
of this discussion with Mrs. Trayner and Miss Nelles?

4

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A. I spoke with Dr. Carlos
Contreras later that day.

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Q. You will recall that yesterday
we looked at the notation in the ward 4A
communication book which you told us was under your
handwriting for July 31st, and you indicated that
you had spoken to Dr. Contreras about Andrew
Bilodeau, do you recall that?

11

A. Yes.

12

13

Q. Did you at the same time
raise with him the case of Amber Dawson?

14

A. I believe I must have, yes.

15

16

17

18

19

Q. Do you recall what you
discussed with him regarding Amber Dawson?

A. I don't recall for certain
what I said, I assume it was to the effect, why
did Amber die, whether they had any post mortem
results.

20

21

22

Q. Was any explanation offered
to you during your discussion with Dr. Contreras
as to why the child had died?

23

24

25

A. No. I recall him saying
that there was an element of surprise.



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Q. Did Dr. Contreras insofar as

3

you could judge the matter seem to be satisfied

4

that there was an explanation for her death at

5

that time?

6

A. He seemed to be quite upset

7

and he was very upset for the mother as well, that

8

is what I recall.

9

Q. Did he tell you why she died?

10

A. I can't recall right at this
moment.

11

Q. Could I ask you to look please

12

at Exhibit 300. If you look under the first tab

13

Mrs. Radojewski, the Ward 4A Communications Book

14

the entries for July 31st.

15

A. Yes.

16

Q. That is at page 5. Is that

17

your note concerning both Andrew Bilodeau and Amber
Dawson?

18

A. Yes.

19

Q. Do you recall whether or not

20

you made this note before or after you spoke to

21

Dr. Contreras?

22

A. I assume I made it after I

23

spoke to Dr. Contreras.

24

Q. And having done so, would it

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be fair of me to suggest from the language of the comments concerning Amber Dawson, that even after you had spoken to Dr. Contreras there was uncertainty as to why Amber Dawson had died?

A. Yes.

Q. And there was no explanation forthcoming to you, at least in that discussion, as to why she had died?

A. That's right.

Q. Is it fair to suggest that at that point the post mortem results however were not available?

A. Yes.

Q. And subsequently they did become available?

A. Yes.

Q. And were you made aware of the results of the post mortem?

A. Dr. Contreras got back to me and told me some of the results.

Q. And I would ask you to turn to the immediate next page in the Communications Book, there is an entry for August the 8th of 1980, is that your writing?

A. Yes, it is.



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Q. You recalled there certain
of the findings on the post mortem of Amber Dawson?

A. Yes.

Q. One of which appears to have
been an abscess on her diaphragm?

A. Yes.

Q. When that information was provided
to you I take it you sent for Dr. Contreras.

A. Yes.

Q. Did you regard that as a
satisfactory explanation of Amber's death?

A. At the time I did, yes.

Q. Was it your impression that Dr.
Contreras held that view?

A. Yes.

Q. Did he suggest to you in com-
municating that information that there was any reason
to doubt further why the child had died, or at least
to question further why the child had died?

A. No, there was no reason.

Q. Did you at any time hear it
suggested, or did anyone suggest to you, be it Mrs.
Trayner or Miss Nelles during your discussions with
them, or during either of your discussions with Dr.
Contreras, that there had been an incident of concern



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arise, concern to the nursing staff, during the
resuscitation efforts of Amber Dawson?

A. No, I don't recall.

Q. Did you ever hear of an episode
having occurred during her resuscitation effort which
caused concern to some of the nurses who were in
attendance?

A. Not that I recall.

Q. Did Dr. Contreras or anyone else
ever suggest to you at any time that digoxin toxicity
may have played a part in this child's death?

A. No, there was no suggestion.

Q. Was it discussed at all as best
as you can recall it?

A. No.

Q. After the information as to
certain of the post mortem findings on Amber Dawson
had been provided to you by Dr. Contreras, did you
at some later point in time have made available to
you the actual autopsy report that had been prepared
at the hospital?

A. No, they were not made available
to nursing staff.

Q. Were you aware of the fact, Ms.
Radojewski, that the hospital pathologist who performed



3 2 the autopsy, Dr. Cutz, had been unable to identify
3 an anatomical cause of death for this child?

4 A. No, I was not aware of that.

5 Q. Until just now?

6 A. Yes.

7 Q. With that in mind, and in light
8 of the concern that was originally expressed regarding
9 her death, and the information that was provided to
10 you with respect to the post mortem results, and
11 specifically the abscess on her diaphragm, has there
12 been since Amber Dawson's death any remaining or
lingering doubt in your own mind as to why she died?

13 MR. ROLAND: Is she asking for doubt
14 at this moment, because this information just came to
15 the witness this moment.

16 MS. CRONK: I think that is a fair
17 observation by my friend, let me attempt it a
different way, sir.

18 Q. As I understand what you have
19 said in the sequence of events, Ms. Radojewski, originally
20 there was concern expressed about Amber Dawson's
21 death and the post mortem results were not then
22 available, do I have that correctly?

23 A. That's right.

24 Q. Subsequently Dr. Contreras did
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4 speak to you again and he informed you at that time that there appeared as a result of the post mortem to have been an abscess on the child's diaphragm.

A. Yes.

Q. You never saw the post mortem report; is it your evidence today that the first time that you learned that there was no apparent anatomical cause of her death was when I just suggested it to you?

THE COMMISSIONER: Well, the real problem I think, as Mr. Roland puts it, is it is going to be difficult in answering this question, because she can't now take time off to study the report.

MS. CRONK: Could I just explore for a moment, sir?

THE COMMISSIONER: Yes, all right.

MS. CRONK: ...whether Ms. Radojewski is certain in her own mind that this information is new to her in the last five minutes.

THE COMMISSIONER: Yes, all right.

Q. Is that your evidence today, Ms. Radojewski?

A. You had, I believe, mentioned it earlier to me.



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Q. Did you have an opportunity before
testifying to review the medical chart of Amber
Dawson?

4

5

A. No, I did not review it before.

6

Q. Before testifying in here?

7

A. No, I did, I'm sorry, I did
review it before yesterday.

8

9

Q. We know that the death of Amber
Lawson was one of those which occurred before the
mortality meetings which were held in September of
1980. As best as you can now recall it, was there
any issue raised at those meetings, particularly the
September 5th meeting that you attended, regarding
the cause of her death?

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A. Could you repeat the first part
of that?

15

16

Q. Let's deal with the September
5th mortality meeting.

17

18

A. Yes.

19

Q. Do you recall any concern being
expressed at that meeting which you attended concern-
ing the cause of Amber Dawson's death? To help
you with that, Ms. Radojewski, it is my understanding
that the child was not specifically recorded in the
minutes of the meeting as having been discussed.

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My question to you is, do you remember her death
being raised at that meeting?

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A. No, her death was not raised at
that meeting.

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Q. We know that subsequently, on
September 26th, there was a second mortality
meeting and we will discuss that further in due
course, but did you attend that meeting as well?

7

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9

A. Yes, I did.

10

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Q. Do you recall Amber Dawson's
death being discussed at that meeting?

12

A. No, I don't.

13

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Q. After the post mortem results
were available, and then I will leave the matter here,
Mr. Commissioner, do you recall any further dis-
cussion amongst anyone of which you were aware,
be it representatives of the nursing staff, or the
medical staff, that there continued to be some un-
answered questions concerning the cause of Amber
Dawson's death?

20

A. Could you repeat the first part
of that, please?

21

22

Q. After the post mortem had been
done on Amber Dawson.

23

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A. Okay.



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Q. Do you at that stage remember any subsequent discussions amongst any member of the nursing or the medical staff suggesting that there were still unanswered questions concerning the cause of that child's death?

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A. Not that I recall.

7

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Q. In your own mind, then, when the post mortem results were on hand, did you have any reason to doubt the cause of the child's death?

9

10

A. Yes, there was some doubt.

11

Q. That was in your own mind?

12

A. Yes.

13

Q. And did you discuss that with any of the physicians connected with the cardiology unit after you knew what the post mortem results were?

14

15

A. I did not find out the post mortem results until prior to coming here.

16

17

Q. I am sorry, we are talking about two different things. We know from what you have told us that Dr. Contreras did discuss with you certain of the findings at autopsy.

18

19

20

A. Yes.

21

Q. That is what I am referring to for the moment.

22

23

A. Okay.

24

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Q. Is the post mortem results.

3

A. I'm sorry.

4

Q. And I am asking you once you knew those results, did you have any reason, even in light of that information, and in light of what Dr. Contreras had told you, to have any remaining doubt as to why that child had died?

8

MR. ROLAND: Sir, there is two different questions now. The question is, did you have any reason to doubt; and she may say, now, I do have reason to doubt. Or is the question, did she doubt whether she had reason or not. I am not sure, I think those questions have been asked, and I am not sure that the witness understands what my friend is trying to get at.

15

MS. CRONK: It is early in the morning, sir, and my friend may be entirely right, I will try to deal with this and then leave the matter.

18

THE COMMISSIONER: Well, there shouldn't be too much excuse early in the morning, at least not with me. It is late in the afternoon I have my troubles. I thought you were asking whether there was a continued doubt in her mind after she had heard about the autopsy results of the perforation of the stomach.

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MS. CRONK: I did, sir.

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THE COMMISSIONER: If there was a
continued doubt. Can we ask that question, will that--

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MR. ROLAND: I have no problem with
the question as long as it is asked consistently in
one way.

7

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THE COMMISSIONER: Yes, all right.

9

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MR. SCOTT: What about the Scott rule
that no question can be more than ten words before
1:00?

11

12

MS. CRONK: We have never taken a vote
on it.

13

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THE COMMISSIONER: It is not a bad rule.
Well, we will revise the question then. The question
now is, and I will try not to exceed ten words; did
you have any lingering doubts as to the cause of
death of this child after you heard about the perfora-
tion of the stomach and the other matters that you did
hear from the autopsy?

19

20

That is well over ten words. Did
you understand it?

21

22

THE WITNESS: Prior to coming here?
I am sorry --

23

24

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THE COMMISSIONER: No, at the time.

THE WITNESS: At the time? No, I



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didn't.

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Q. And then finally in light of the information that you now know about the preparation of the autopsy report and the apparent inability to pinpoint an anatomical cause of death, does that give you any reason in your own mind --

THE COMMISSIONER: I am not too sure that is fair, I am not too sure that is fair. You are now asking her something that she has just got, got relatively recently and asking her for a medical opinion on it.



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MR. ROLAND: Sir, I don't want to be particularly difficult but we have heard from all the experts of all kinds.

THE COMMISSIONER: Yes, I know we have, yes.

MR. ROLAND: And I really don't think whatever her opinion is is particularly useful to us at this stage having heard from all the doctors to give an opinion today.

THE COMMISSIONER: No. I think there is something on what Mr. Roland has said. There may be some relevance as to whether there was some doubt about the cause of death back at that time, but her present opinion, and I am not belittling her present opinion, it's a great deal better than mine, but is it, in light of the fact we have had all of this evidence from the doctors and from everybody who has examined all the charts and all their qualifications, is it helpful to have her present opinion now?

MS. CRONK: I am content sir to leave the matter there.

THE COMMISSIONER: Yes, all right.

MS. CRONK: Q. May we then with some relief perhaps for both us turn to the next child, Mrs. Radojewski, that's the case of Lillian Hoos.



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You will recall that she died on July 31st.

3

A. Yes.

4

Q. Do you have any recollection on
having seen this child prior to her death?

5

A. I don't recall this child.

6

7

Q. Do you recall any of the
circumstances surrounding her death?

8

A. No, I am sorry, I don't.

9

10

Q. Well, you will recall that in
the note which you did make in the Ward 4A

11

Communications Book on July 31st it did include
reference to Lillian Hoos?

12

13

A. Yes.

14

Q. Do you recall that?

15

A. Yes.

16

Q. Was this one of the children that
you discussed with Dr. Contreras?

17

A. Yes, it was.

18

19

Q. Do you remember concerns having
been expressed to you by the nurses on 4A or 4B
regarding the cause of that child's death?

20

21

A. I am sure in order for me to have
brought it up with Dr. Contreras there were concerns
raised, I just have no recollection of them.

22

23

Q. All right. Once again, could I

24

25



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4

ask you to look at your note please in the 4A
Communication Book for July 31st. It is at page 5,
Mrs. Radojewski.

5

A. Yes.

6

Q. Do you have that?

7

A. Yes.

8

9

10

11

12

13

Q. All right. Would it be fair of
me to suggest on the basis of the notation which you
made in the 4A Communication Book that at the time
that you wrote that note, having spoken to
Dr. Contreras, there appeared to be some element of
uncertainty with respect to the cause of death of this
child as well?

14

A. Yes, by what I have written.

15

16

17

Q. And you have told us that you did
speak on a subsequent occasion with Dr. Contreras
regarding Amber Dawson. Did you do so with respect to
Lillian Hoos?

18

19

20

21

22

THE COMMISSIONER: I think it is
unlikely she will remember that, but maybe you do.
Maybe you do remember. If you don't remember the death
and you don't remember anything about it, it is
unlikely she will remember whether she did speak to
Dr. Contreras about this.

23

24

25

MS. CRONK: Q. And the entries in the



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Ward 4A Communication Book don't assist you in any way in recalling any further discussions that might have taken place with respect to this child?

5

A. I don't recall anything more.

6

7

8

9

Q. All right, that's fair. Could we discuss then the case of Phillip Turner. He as well died at the end of July, beginning of August, August 1st on Ward 4A and he had been a patient, as I understand it, from time to time on your ward?

10

11

A. I believe Phillip was transferred July 30th. I don't think we had seen him before that.

12

Q. I am sorry?

13

14

A. I don't think we had seen him before that.

15

16

Q. Did you have an opportunity to see him following his admission to 4A?

17

18

19

20

A. Yes, I did.

21

22

23

24

25

Q. It is my understanding that you had worked an eight hour day shift on July 31st, the day prior to his death, and as well on July 30th, is that correct?

A. Yes.

Q. All right. Could I ask you again if you still have them there to turn to the tour end reports, this time with respect to Phillip Turner. I



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would ask you first if you would please to look at page 17, at the back specifically on page 17. These are the entries for July 30th, Mrs. Radojewski. Are the entries made on the day shift your writing?

6

A. Yes, they are.

7

8

9

10

Q. All right. And this is the day I take it when the child was transferred from the Intensive Care Unit to your ward at approximately 2 o'clock in the afternoon?

11

A. Yes.

12

13

14

15

Q. All right. Based on the note which you did make at the end of the day shift when you were on duty, was there anything about that child's condition then that caused you to be concerned?

16

A. Can you repeat the question, please?

17

18

19

20

Q. Based on what you observed that day and the notation that you made at the end of your shift in the tour end report, was there anything about his condition then that caused you to be particularly concerned?

21

22

23

24

25

A. By the notation that's on the tour end report, no, but I had known of Phillip Turner from Intensive Care and I was uncomfortable with him being on the ward.



1

2

Q. Had you seen Phillip Turner in
Intensive Care?

3

4

A. I don't recall. It's possible I
did but I knew of him from ICU.

5

6

Q. All right. And by that do I take
it that you knew that the child was coming up from
ICU to your ward?

7

8

A. Yes.

9

10

Q. All right. Did you have concerns
about that?

11

A. Could I explain?

12

Q. Please.

13

A. Part of what Miss Costello and I
did jointly was make daily visits to Intensive Care to
look at the patients that would eventually be coming
to our ward and patients that were ours to begin with.
We shared that duty, we went alternate days. When I
say I have knowledge of him, it was either that I saw
him in ICU or Miss Costello, and we used to write a
very brief summary and I knew that he had had a lot of
chest problems, left lung problems to be specific.

20

21

Q. All right. And we know that he
did in fact come from the ICU to the ward on July 30th?

22

A. Yes.

23

Q. And at that time, given what you

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knew of his condition and what you observed, it would appear that at least during the early evening and during the night shift his condition was considered relatively stable, according to the tour end report. Is that fair?

A. Yes.

Q. And on July 31st, if you could turn to the next page if you will, again at the back. This is the day prior to his death. Are the day shift entries again yours with respect to this child?

A. Yes.

Q. And there appears to be a suggestion that the child should be transferred back to the Intensive Care Unit. Do you see that?

A. Yes.

Q. Was it your view at the time that he should be transferred back to the Intensive Care Unit?

A. Yes.

Q. Can you help me if you can recall it now as to why you thought that should happen?

A. He had had a very, if I can use the term, rocky post-operative course in Intensive Care and he seemed to be experiencing the same lung problems that he had in Intensive Care on the ward



E 8 1
2 I didn't feel that we were equipped to handle an
3 emergency if it came up.

4 Q. In light of your view on the
5 matter, were there discussions with either any of the
6 nursing supervisors during the day shift or any of the
7 doctors connected with the ward then as to whether or
8 not the child could be admitted to the Intensive Care
Unit?

9 A. I know I took my concerns to
10 someone, I just don't recall who.

11 Q. And I take it that despite your
12 concern about the matter the child was not then
13 transferred back to the Intensive Care Unit, he
14 remained on the ward?

15 A. Yes.

16 Q. And we know that he died during
17 the course of the long night shift that night?

18 A. Yes.

19 Q. And if we look at the evening
20 shift notes with respect to the child, we see there
21 an indication as to instability?

22 A. Yes.

23 Q. And later during the course of
24 the long night shift, I take it that would be after
25 11 o'clock in the evening, there is an indication that



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the left lung had collapsed and the child's condition had deteriorated?

A. Yes.

Q. All right. When you returned to the hospital and learned of Phillip Turner's death, given what you knew about his condition on the 31st of July, did you have any concerns as to what had caused him to die?

A. No.

Q. Were any concerns expressed to you by anyone else regarding the reason for his death?

A. Not that I recall.

Q. Do you recall any discussions at any time or any suggestion being made to you at any time that there might have been the involvement of a drug either as a contributing factor in his death or the cause of his death?

A. No.

Q. All right. By the time that Phillip Turner died the 1st of August, Mrs. Radojewski, there had been a series of deaths on Wards 4A/4B. If we count Laura Woodcock on June 30th and include Phillip Turner on the 1st of August, the number at that point is 7. I take it that you were aware that these deaths had occurred and had been informed if you weren't



1

2 actually present that the children had died?

3

A. Yes.

4

5 Q. Were you at that time aware that
6 many of these deaths had occurred during the course of
7 the long night nursing shift, that many had occurred
8 in the early hours of that long night nursing shift
9 in the morning?

8

A. I was aware that they were on long
9 night.

10

11 Q. Did you by the time of Phillip
12 Turner's death observe any pattern to these deaths
13 that had taken place in July?

13

A. No.

14

15 Q. All right. You have told us that
16 you knew they had taken place on the long night shift.
17 Were you conscious at the beginning of August that
18 they appeared to be taking place within a specific
19 period of time on the long night shift? Was that
20 something of which you were aware?

19

A. I may have been.

20

21 Q. Were you aware at that time that
22 many of these deaths were occurring on Ward 4A?

21

A. Yes.

22

23 Q. Were you aware at that time that
24 many of these deaths were taking place in the presence
25

24

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E 10



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of the members of the same nursing team?

3

A. Yes.

4

Q. Did those factors when you

5

realized them at the end of July and the beginning of
August have any significance for you?

6

7

A. I felt that they had had an
extremely rough month, that they were - it was just
coincidence and their bad luck.

8

9

Q. And by their bad luck who are you

10

referring to?

11

A. The team of nurses that were on

12

nights.

13

Q. That I take it was Phyllis

14

Trayner's team?

15

A. As I recall, yes.

16

Q. Did you have any discussions with

17

them concerning the series of deaths that had taken
place?

18

A. I made a note, I believe we met

19

several times in August and I know I made a note in

20

the ward meeting book that we had talked about the
recent arrests.

21

Q. Do you recall when that was?

22

A. Early August.

23

Q. Could I ask you to turn to the

24

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last tab of Exhibit 300, which is the Ward 4A Meeting Book and to the entry for August 5th, 1980. I am sorry, I can't help you with the page, Mrs. Radojewski, but the entry is August 5th.

THE COMMISSIONER: It is page 175 on mine.

MS. CRONK: Q. Do you have that?

A. Yes.

Q. The entry in the meeting book appears to suggest that on that day there was a meeting amongst Phyllis Trayner, Susan Nelles, and I take that to be Sui Scott?

A. Yes.

Q. Do you recall whether or not you were at that meeting?

A. Yes.

Q. Is that entry in your handwriting?

A. The August 5/80 and the names of Phyllis, Sue Nelles and Sui is my writing, yes.

Q. Do I take it from that that the description of what was discussed is not in your writing?

A. It's not mine.

Q. All right. Do you recall now what was discussed at that meeting?



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A. Yes, we talked about the discussion of overtime, read memorandums, looked at a folder in which we were to document overtime and we discussed personal team problems re arrests and causes of death.

Q. Were there concerns expressed by any of the nurses in attendance at that meeting, Mrs. Radojewski, concerning the cause of death of any of the children who had died up until that point in time?

A. Could you repeat that, please?

Q. Were there concerns expressed by any of the nurses who were at that meeting as to the cause of death of any of the children who had died on the wards up to that point in time?

A. There may have been, yes.

Q. Do you recall now whether there were?

A. I can't remember specifics.

Q. Do you remember any specific child, if any, that appeared to be a source of concern to the nurses at that meeting?

A. No, I don't recall a specific child.

Q. What did you understand the purpose of the meeting to be insofar as it related to



E 14 1
2 in part the discussion of the arrests and the causes
3 of death?

4 A. They were concerned that they
5 had assessed the children properly, they were wonder-
6 ing from a nursing point of view if there were any
7 observations that they may have missed that they could
8 have picked up and perhaps reported to the doctors
9 sooner. They were looking for reassurance that they
10 were doing their job properly and that they were
11 functioning well in arrests. It was mostly a meeting
12 about my being supportive of them and trying to
13 reassure them of their ability.

14 Q. Was it your impression that at
15 least part of the need for reassurance that came
16 forward at that meeting had to do with the fact that
17 there had been far more deaths in the last five weeks
18 prior to the meeting on the wards that had previously
19 been experienced?

20 A. Yes, some of it was, yes.

21 Q. And they were coping, the nurses
22 on that team who met with you that day, with more
23 arrests than they had seen before?

24 A. Yes, it was a stressful time for
25 them.

Q. Do you have any recollection at



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all now looking back on that meeting as to whether or
not any particular child or children stood out in any
way as being a source of concern to those nurses?

A. I don't recall a specific child,
no.

Q. What did you do, Mrs. Radojewski,
as a result of that meeting with the nurses at the
beginning of August when you had observed that there
had been these deaths, that they were happening on
Ward 4A in association with the same nursing team?
Did you carry the matter forward in any way by
discussing it with others?

A. I don't recall at that point in
time. Can you repeat the question, please?

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Q. After you had had this meeting with Mrs. Trayner, Miss Nelles and Mrs. Scott on --

A. Yes.

Q. -- August 5th, at that time you told us that you were aware that these arrests were occurring on the long night shifts in the presence of the same nursing team for the most part?

A. Yes.

Q. My question to you was: did you after that meeting in the face of that information carry the matter forward by discussing it with anyone else at that time?

A. Not that I recall, no.

Q. Did you in your own mind in light of the fact that there was an increase in deaths on these wards search for an explanation as to what might be causing those deaths?

A. No, I did not.

Q. Was it a matter that at that time you attributed to anything other than, as you have described it, coincidence and bad luck?

A. I didn't feel it was anything else but that.

Q. All right. You don't recall any discussions with any of the physicians connected



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with the Cardiology Unit or I take it with any of
your nursing supervisors at that point with respect
to these deaths?

5

A. That is right.

6

7

Q. Can we turn then to the death
of Kelly Monteith? This child died on August 19th;
again on Ward 4A.

8

9

10

11

12

13

It is my understanding that - and you
will recall we discussed this yesterday - that you
worked the 12-hour nursing shift on August 18th the
day before her death, and an 8-hour day shift on
August 19th the day following her death. Do I have
that correctly?

14

A. Yes.

15

16

Q. Could I ask you if you would,
please, to turn to page 25 of the tour end reports
with respect to Kelly Monteith.

17

18

If we could start, please, with the
entry for August 18th, the day before she died.

19

A. I'm sorry, page 25?

20

Q. Page 25.

21

A. Yes.

22

23

24

25

Q. Once again is the entry for the
8-hour day shift - in this case, in your case, it
would be a 12-hour day shift - on August 18th in your
writing?



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A. Yes.

3

Q. And on the basis of your

4

description of her condition at that time can you

5

help me, please, as to whether or not you regarded

6

her to be in a critical condition at the end of your
shift?

7

A. No, I did not regard her to

8

be critical.

9

Q. As I read the note it would

10

appear that she was on shared nursing care at that

11

time?

12

A. Yes.

13

Q. Would it be fair to take

14

from the assignment of shared nursing care duties

15

that there was a degree of concern about the child

16

and that she required a degree of monitoring that

17

couldn't be provided unless there were shared care

nursing in place?

18

A. Yes. She was certainly at

19

some risk.

20

Q. And the child, as I understand

21

it, had also had a cardiac catheter procedure done

22

earlier that morning?

23

A. Yes.

24

Q. Did she appear when you last

25



F.4

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saw her on the 18th to be recovering well from that
procedure?

3

4

A. I don't recall specifically
on the 18th.

5

6

Q. Do you recall now having had
any specific concerns about the child when you left
work that day?

7

8

A. No, I am sorry, I don't recall.

9

10

Q. I take it you would have
learned of her death the next day when you reported
for duty?

11

12

A. Yes.

13

14

Q. The 19th. Do you recall at
that time whether or not any concerns were expressed
to you by any members of the nursing staff as to why
that child had died?

15

16

A. I don't recall any concerns
being raised.

17

18

Q. Do you recall any concerns
being raised or any discussions in which you
participated with any of the physicians connected
with the unit concerning the cause of that child's
death?

19

20

21

22

A. Not that I recall.

23

24

Q. Did you yourself at the time,

25



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having regard to what you described as her condition the day prior to her death, consider her death to be unexpected?

5

6

7

A. Her death was explainable to me. I am very uncomfortable with the term "unexpected".

8

9

10

11

12

13

Q.

We have had some difficulty with that with other witnesses.

A.

Yes.

Q.

By "unexpected" were you in your own mind at that time concerned that the child may have died sooner than you would have anticipated given that you had seen her the day before?

A.

No.

Q.

When you say that the child's death was explainable, on what basis did you feel her death was explainable?

A.

The cardiac lesion which she had on the result of the cath.

Q.

Was the result of the catheter investigation known to you on the 18th of August when she returned from the cath. lab?

A.

Yes, and I believe we knew before. We had a definite impression before she went to the cath what her diagnosis was.

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Q At any time was it ever suggested to you by anyone that there might have been a drug, be it digoxin or any other drug, involved in, whether as a contributing factor or otherwise, the death of this child?

A No.

Q Paul Murphy is another child who died on Ward 4A during the month of August. You recall that we discussed him yesterday in the context of a medication error which appears to have occurred.

Do you remember this child, Mrs. Radojewski?

A Yes, I do.

Q Am I correct in this case that this child had, regrettably, been in and out of the Hospital on numerous occasions during the course of his life.

A Yes.

Q And on many of those occasions I take it he had been a patient on your ward?

A Yes, and 5A.

Q And on 5A before the relocation?

A Yes.

Q As I understand it you worked on August 22nd, an 8-hour day shift, but did not work



F.7

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2

on August 23rd which was the actual day of his death.

3

Do I have that correctly?

4

A. Yes.

5

Q. Do you recall seeing the

6

child the day before he died? That is on August 22nd?

7

A. I recall that he was in

8

Room 423 and I recall seeing him, yes, on nursing rounds.

9

Q. All right. Could you look at

10

page 28, if you would, please, the tour end report.

11

Again I would ask you to look at the back of it if

12

you would, please. These are the entries for the day

13

prior to the child's death, Mrs. Radojewski.

Are they yours?

14

A. For the day shift, yes.

15

Q. All right. And based on the

16

entries that you made in the tour end report was there

17

at that time, that is the end of your shift, any

18

reason to regard the child's condition as being

19

critical?

A. No.

20

Q. Indeed, if we look to the

21

far right of the entries made on August 22nd it

22

appears that the nursing view, at least by the author

23

at that time, was that his condition was stable.

24

25



F.8

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2

A. Yes.

3

Q. And then if we look to the

4

tour end report for August 23rd, the day of his death,

5

just to refresh your memory, he died at approximately

6

10:28 in the evening on the 23rd of August, and I

7

direct your attention to the 8-hour day shift entry.

8

On the basis of that it appears that

9

the child's condition was, as described, more confused
that day.

10

A. Yes.

11

Q. It also suggested there was

12

a "do not resuscitate order" in place with respect to
the child?

13

A. Yes.

14

Q. After you learned of his

15

death when you returned to work, Mrs. Radojewski,

16

were any concerns expressed to you by any members

17

of the nursing staff or by anyone else as to the cause

18

of that child's death?

19

A. No. There were none raised.

20

Q. Is it fair to suggest that

21

during the period on the basis of your observations

22

of him, that during the period of his last admission

23

to the Hospital his condition appeared to be gradually

24

deteriorating?

25



F.9

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A. Yes, he deteriorated quite a

3

bit.

4

Q. And the decision had been

5

made to not undertake any resuscitation efforts with

6

respect to the child should he go into an arrest?

7

A. Yes.

8

Q. And that in fact was what

happened?

9

A. Yes.

10

MS. CRONK: Thank you.

11

Sir, could we take our break now?

12

THE COMMISSIONER: Yes. Twenty

minutes.

13

14

--- Short recess.

15

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F.10

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-- On resuming:

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THE COMMISSIONER: Yes, Miss Cronk?

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MS. CRONK: Q. Mrs. Radojewski, there was another child who died during the month of August, 1980. That is Antonio Velasquez who died on the 24th of August. In fact as I understand it he died on the same long night nursing shift as Pual Murphy. Do I have that correctly? I'm sorry - that's right, Paul Murphy died on August 23rd at 10:28 in the evening and later the same night at approximately 4:30 in the morning Antonio Velasquez died?

12

A. Yes.

13

14

15

Q. Is that correct? And there were two deaths on the one long night nursing shift during that two-day period, August 23rd to August 24th?

16

A. During the same long night, yes.

17

18

19

Q. We have heard from a number of witnesses, Mrs. Radojewski, that the death of this child was to them, given his condition, somewhat unexpected.

20

What was your view when you learned of his death?

21

A. I was surprised at his death.

22

23

Q. Had you seen the child prior to his death while he was on the ward?

24

25



F.11

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2

A. Yes.

3

Q. Do you recall now when that

4

was?

5

A. I saw him when he was

6

transferred up from Intensive Care.

7

Q. All right. It is my under-

8

standing that that occurred on August 22nd?

9

A. Yes.

10

Q. Do you recall what his

11

condition was post operatively when he came to the
ward from the Intensive Care Unit?

12

A. He appeared stable, although

13

he was extremely uncomfortable. He seemed to be
having what we thought was a lot of pain.

14

Q. At that time were there any

15

special measures taken with respect to nursing care,

16

and by that I mean either shared care nursing or

17

constant care nursing for the child?

18

A. Not that I recall.

19

Q. And you, as I understand it,

20

were not in the Hospital on August 23rd, but you did

21

return to the Hospital on the 25th of August, and I

22

assume that is when you would first have learned of
his death?

23

A. Yes.

24

25



F.12

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Q. Did you as well learn on that day that two doses of Narcan had been administered to him to counteract an apparent adverse reaction to codeine?

A. Yes.

Q. How did you learn that?

A. It was reported to me by the long night people when I came on duty.

Q. Do you recall specifically who you discussed the death of Antonio Velasquez with when you came in that day?

A. I remember talking to Mrs. Trayner that morning.

Q. All right. What did Mrs. Trayner tell you in relation to the fact that two doses of Narcan had been given to the child to counteract the codeine reaction?

A. I don't recall specifically anything else. I am sure she said other things; I just don't recall them.

Q. Do you remember concern being expressed either by Mrs. Trayner or any other members of the long night nursing team that had been on duty that night as to why the child had died?

A. Yes, there was concern.



F.13

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Q Did there seem to be puzzle-
ment in their own minds insofar as you could tell as
to why he died?

A Yes.

Q Did you discuss his death
with any of the physicians who were on the ward that
day?

A I am unsure if it was that
day, but I can remember discussing with Dr. Freedom
about Antonio Velasquez.

Q How did that come about?

A It wasn't as I recall a formal
meeting. He was -- stopped to talk with me on the
ward, and we got on to - we talked about Antonio
Velasquez, and there were concerns.

I remember asking him about the Narcan.
We hadn't had that much experience with it. It was
always available on the ward but we hadn't had much
experience in its use, and he had commented that it
was - I was under the understanding that he had
checked some literature and he had said that it was
impossible to give an overdose of Narcan. And I
can't remember if it was at that particular time
but that he had called the coroner and the coroner
was not interested. He had I assumed explained what



F.14

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had happened with Antonio Velasquez, and that was the response.

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Q Do you recall any other matters being discussed during that conversation with Dr. Freedom regarding Antonio Velasquez?

6

7

A No. That's all I remember.

8

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10

11

Q You said that the drug Narcan was available on the ward but you didn't have much experience with it. Would I fairly take from that that it was not commonly used in the treatment of patients on Wards 4A/4B?

12

A Yes, that is what I mean.

13

14

Q Do you recall whether or not anyone else was present during your discussion with Dr. Freedom about this matter?

15

16

17

A There certainly could have been. It was just in the nursing station and there could have been many people around.

18

19

20

Q But you don't now recall?

A I don't recall how many were there.

21

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Q When you came into the ward on August 25th which was the day after Antonio Velasquez died, did you that day or the next see Dr. Wilkinson who was the resident who was on duty during the arrest of that child?



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A. I am sure that I would have seen him because I would have taken him on rounds in the morning as part of my normal course.

Q. Do you recall at any point discussing this child's death with him?

A. I don't recall for sure.

Q. Had you ever before in your experience as a nurse, and particularly as a cardiology nurse, been exposed to or heard of a patient dying from an adverse reaction to Narcan?

A. No.

Q. That was something unusual in your experience?

A. Yes.

Q. After your discussion with Dr. Freedom concerning the matter did you discuss the child's death with any other physician connected with that unit?

A. I don't recall.

Q. We know that you attended the September 26th morbidity and mortality meeting that was held at the Hospital. You have told us that. Did you keep notes of that meeting as you had for the meeting on September 5th?

A. No, I did not.

-



F.16

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Q Can you tell me why you didn't?

3

A I didn't have the book with

4

me to record them. Mrs. Croswell recorded them for
that meeting.

5

6

Q I am sorry, is that Diane

Croswell?

7

A Yes.

8

Q And what was her position on

9

Ward 4A/4B?

10

A At the time of the meeting?

11

Q Yes?

12

A Her position was a teaching

team leader, and I believe on that particular day
that she was in charge of the ward.

14

Q All right. As best as you

15

can now recall it did your discussion with Dr. Freedom
take place before or after the mortality meeting on
September 26th?

17

18

A It is my recollection it was

before.

19

20

Q All right. And do you recall

now that the death of Antonio Velasquez was again
raised at that mortality meeting on September 26th?

21

22

Mr. Registrar, could you show the

23

witness if you would, please, Exhibit 51.

24

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TORONTO, ONTARIO

Radojewski, dr.ex. 5076
(Cronk)

F.17

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To assist you, these are the minutes,
Mrs. Radojewski, of the meeting that took place on
September 26th.



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DM/PS

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Could I ask you further, Ms. Radojewski,
first before you look at the minutes, was it your
impression on the basis of discussions that you had
had with Dr. Freedom, that there was concern in his
mind as to why the child had died?

A. I was left with that impression,
yes.

Q. And after the meeting of
September the 26th, when his death was discussed along
with that of, I believe, two other children, were you
reassured by what you had heard at that meeting
concerning the cause of his death?

A. I accepted the cause as being
an idiosyncratic response to the Narcan and the
codeine. I had heard in the past, I knew that that
was definitely a possibility, I just had not had any
in my experience.

Q. You say that you accepted the
cause of death as being an idiosyncratic reaction to
the Narcan. Did you, following the meeting of September
26th, in light of the discussion which had taken place,
have any lingering doubt in your own mind as to why
the child had died?

A. I accepted that.

Q. Do you recall now whether there



1
2 was any discussion at that meeting of September 26th
3 as to whether the death of the child should be reported
4 to the coroner, or any discussion regarding involve-
5 ment of the coroner's office?

6 A. I don't recall.

7 Q. Other than the mention of it
8 which was made during your discussion with Dr.
9 Freedom, was the issue of the involvement of the
10 coroner's offices ever raised again of which you are
11 aware with respect to this child?

12 THE COMMISSIONER: Am I not right it
13 was reported to the coroner, but the coroner would
14 not have it?

15 MS. CRONK: As I understand it, the
16 evidence that we have heard from a number of
17 witnesses, there was a series of phone calls.

18 THE COMMISSIONER: Yes.

19 MS. CRONK: More than one, and I
20 am sorry for the lateness of the recollection, sir.

21 THE COMMISSIONER: No, I am just
22 quarrelling as to whether it should be reported to
23 the coroner, it was reported to the coroner, it just
24 was not taken up by the coroner.

25 Q. The intent of the question is,
was there any further discussion of which you were aware



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after that meeting of September 26th, Ms. Radojewski,
concerning the involvement of the coroner's office
with this death?

4

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A. Not that I was aware.

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Q. Prior to the meeting of
September 26th, there had of course been two other
deaths on the ward, one was that of Laurette
Heyworth who died on September 2nd, and she in fact
died before the first mortality meeting on September
5th. As well Brian Gage died on the ward on
September 25th, the day before the mortality meeting
on September 26th. Can we deal first with Laurette
Heyworth. As I understand it, you worked an eight
hour day on September 2nd, it was the day of her
death, do I have that correctly?

15

A. Yes.

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Q. Did you, as best as you can now
recall it, report for work at your normal time of
duty, that is, at approximately 7:00 that morning?

20

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A. I am sure I did.
Q. Our information today, Ms.
Radojewski, has been that that child was pronounced
dead at approximately 8:30 in the morning. I take
it then that that would have been within an hour or
so of the completion of shift change that morning.



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A. Yes.

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Q. Do you recall when you arrived
on the ward, was the child then in an arrest
situation?

5

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A. No, she was not.

7

8

Q. Do you recall now what her
condition was when you did take report that morning,
having arrived at work?

9

10

11

A. I don't recall when I took
report, I do remember seeing her on nursing rounds
after report.

12

13

Q. What was her condition at that
time?

14

15

A. She was having some difficulty
breathing and she seemed to be very uncomfortable,
and for the time being looked relatively stable.

16

17

18

19

Q. Would you have done your nursing
rounds that morning, as best you can now recall it, at
the time when you normally did, that is, immediately
after taken report?

20

21

22

A. It is possible.

Q. I'm sorry.

A. Can you just repeat the question
please?

23

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25

Q. You have told us previously that



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your normal pattern of activity during an eight
hour day shift was to first, after you had arrived
on the ward, to take a formal report from the team
leader or nurse in charge who was leaving the hospital,
do I have that correctly?

6

A. Yes.

7

8

Q. And then you would do your
nursing rounds for that morning with the team leader?

9

A. Yes.

10

11

Q. Do you have any recollection now
that you did not observe your normal pattern that
morning?

12

13

A. No, I am sure I stuck to my normal
pattern.

14

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Q. If that was the case, would I
be fair in suggesting you would have been doing your
nursing rounds and thus seen Laurette Heyworth some
time between 7:15 and approximately 25 to 8 that
morning.

19

20

A. I don't know if I would have
seen her before 25 to 8, I probably would have seen
her around 8.

21

22

Q. At that time you told us that
her condition was relatively stable.

23

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A. Yes.



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Q. Were you actually present during
her arrest?

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A. No.

5

Q. How did you become aware that
she had gone into an arrest?

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A. I had just left to take my morning
coffee break which is not the same time as the staff,
and I was paged in the cafeteria to return to the
ward, and as I came up I was told to go to her room
and there I was informed that she had arrested.

8

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Q. Had she been pronounced dead at
the time you returned back to the ward?

12

13

A. Yes.

14

Q. Who was in the room when you
entered it?

15

16

A. It was a relief nurse, I am sorry,
I don't remember her name, and Dr. Jedeikin and
Susan Nelles.

17

18

19

Q. When you went for your coffee
break that morning, having seen the child on your
rounds, was it your impression then that she was at
serious risk of dying in the immediate future?

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A. I would not have left for my
coffee break if I thought she was going to run into
trouble immediately.

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Q. So at the time that you saw her that morning, which you have said would have been some time around 8:00, or before 8:00, she did not, I would suggest, then appear to be in the process of dying.

A. That's right.

Q. Could I ask you to turn please to the tour end reports starting at page 40; do you have that?

A. Yes.

Q. These are the entries, Ms. Radojewski, for September 1st, the day prior to the child's death. I draw your attention particularly to the evening nursing note and as well to the nursing note for the last night shift. The suggestion is made in the long night shift, note:

"That the doctor should speak to the child's parents..."

Am I reading that correctly?

A. Yes.

Q. And that she had had a terrible night.

A. Yes.

Q. And if we turn to the prior page, page 39, and the tour end entry for that child on the 31st of August, once again, if we look at the



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long night nursing shift note there is an indication
that the child has been up and down all night.

4

A. Yes.

5

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Q. That suggests, does it not, that
the child's condition was wavering during the
course of that evening, and the following night she
in fact had what the nurses perceived to be a very
difficult night indeed.

9

A. Yes.

10

11

12

13

Q. Did the tour end report, in your
view for both of those days, suggest with respect
to her condition a continuing state of some concern
over those two days?

14

A. Would you repeat the first part,
please?

15

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19

Q. Do the tour end reports over those
first two days, particularly with reference to the
passages I have drawn to your attention, suggest
a continuing state of concern with respect to this
child's condition?

20

A. Yes.

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Q. I suggest to you that the informa-
tion and the evidence before the Commissioner today
indicates that this child was pronounced dead at
approximately 8:30 in the morning. Having regard to



1
2 the fact that you did not consider her condition to
3 be grave when you left the ward, can you help me as
4 to when you did leave the ward that morning for your
5 coffee break?

6 A. I don't recall the exact time
7 that I left, no.

8 Q. It would be some time after you
9 had done your first nursing round?

10 A. Yes, and I remember checking with
11 the team leader, because Laurette was assigned a relief
12 nurse and we were not in the habit of assigning
13 relief nurses to patients that were acutely ill, or
14 in the process of dying, we just didn't do it. I
15 remember checking with her to see if it was okay if
16 I went down quickly for a break, if she was happy
17 with the situation, and she said, "Sure".

18 Q. If you had completed your rounds
19 some time at approximately 8:00 in the morning, is
20 that fair?

21 A. Yes.

22 Q. And you had seen Laurette and
23 then went for your coffee break and was summoned back
24 up, would it be fair to suggest that if indeed she
25 was pronounced dead at 8:30 that the onset of her
terminal events and the arrest itself, the onset itself



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was both sudden and it progressed very rapidly.

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A. It did progress very rapidly.

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Q. Do you recall that morning after her death any concerns being expressed to you, either by any of the physicians who had been in attendance during her arrest, or by any of the nurses who had been there, any concerns regarding the cause of her death?

9

10

A. No, I don't recall any concerns being raised.

11

12

13

Q. Did there seem to be any uncertainty as to why she had died amongst any of those persons then on the ward?

14

15

A. No.

16

17

18

Q. Was there in your own mind at the time?

A. No.

19

20

Q. Did you regard her death when it did happen as being unexpected?

A. No, I did not regard it as being unexpected.

21

22

Q. Do I take from that, that that was so having regard to what you knew of the child's medical condition and the disease state?

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A. Yes.



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Q. Did you at any time after having come on duty that morning at approximately 7:00, Ms. Radojewski, observe anyone administering any medication to Laurette Heyworth at any time?

A. I don't recall that I did see anyone.

Q. Was it ever suggested to you by any member of the nursing staff, or any member of the medical staff connected with the unit, that there was a possibility that a drug had been involved as a contributing factor in that child's death?

A. No, it was not suggested to me.

Q. Was it ever suggested that digoxin particularly may have been involved in causing her death?

A. No.

Q. Did that occur to you for any reason at the time?

A. No, it did not.

Q. I have mentioned as well that the second death in September of interest to me is that of Brian Gage, he died on September 25th, and you will recall that is the day before the mortality meeting, the second mortality meeting held on September 26th. Do you have any recollection of having



1
2 seen this child, or any of the circumstances surround-
3 ing his death?

4 A. I tried to remember this in-
5 fant and I can't, I have no recall of Brian Gage.

6 Q. You have no recall of any dis-
7 cussions that may have taken place concerning his
8 death?

9 A. That's right.

10 Q. By the time the second mortality
11 meeting had been held on September 26th, Ms.
12 Radojewski, there had, of course, as we know been
13 a number of deaths, not only during the month of
14 July, but throughout the month of August on those
15 wards. In addition to those which occurred in July
16 there were five in August and my recollection is there
17 were two or three in the month of September.

18 THE COMMISSIONER: Two.

19 Q. Two in September and three in
20 October, all of which took place -- well, let's
21 deal simply with those up until the time of that
22 mortality meeting on September 25th.

23 The total number of deaths on those
24 two wards by the meeting of September 26th then
25 counting Laura Woodcock was 13. I take it from what
you have told us before that as you were aware of the



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deaths in July, you similarly were aware of those
which occurred in the months of August and September?

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A. Yes.

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G-2
DM/PS

Q. Did you observe at the time that those deaths as well appeared to be happening in the presence of the members of one nursing team, namely, Phyllis Trayner's nursing team?

A. Yes.

Q. And did you know then as well that most of those deaths, although not all, most of those deaths were occurring during the long night shift in the early hours of the morning?

A. I remember being aware that it was long nights.

Q. And when those -- when you made those observations, or when those facts were known to you, particularly having regard to the fact that you were attending a mortality meeting on September 25th, the purpose of which was to discuss the deaths of some of these children, is that correct?

A. Yes.

Q. Did you attach any significance to the fact that these deaths were occurring again on the long night shift, and again it would appear in the presence of the same nursing team?

A. No.

Q. You have told me before, Mrs. Radojewski, that by the end of July when you observed



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the increase in these deaths, that you thought it was a matter of bad luck, a matter of coincidence that it would be associated with one team, do I have that correctly?

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A. Yes.

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Q. Did you by the time you attended that mortality meeting towards the end of September, search in your own mind for any explanation as to why those deaths would have continued over the months of August and September?

11

A. No.

12

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Q. Did any explanation come to mind, to you, other than the possibility that it was bad luck and coincidence by the end of September?

15

A. No.

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19

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Q. Would it be fair of me to suggest, Ms. Radojewski, that were it a matter of coincidence at that time, and were it a matter of bad luck, that it was bad luck indeed having regard to the fact that these deaths all appeared to be occurring in the presence of one nursing team?

21

A. Could you repeat that, please?

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Q. If it were purely a matter of bad luck, and purely a matter of coincidence that it was indeed bad luck of an extraordinary degree because



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most of these deaths appeared to be occurring only
with one nursing team in attendance.

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THE COMMISSIONER: Yes, Mr. Olah.

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MR. OLAH: Mr. Commissioner, perhaps
my friend could specify the members of the team, she
has talked about members of the Trayner team. I would
like to add clearly for the record that certainly up
until September 2nd my client was not a member of
the team, and in fact I think questioning of this
witness will indicate that my client was never formally
a member of the Trayner team, but that she floated
between the teams.

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THE COMMISSIONER: Yes..
Well, I had that in mind in any event, if that is of
any consolation to you.

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MS. CRONK: Sir, my mind was not
directed towards Ms. Brownless at all.

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THE COMMISSIONER: It was one team,
though, we have to accept that it was a team. Your
complaint is that your client should not be
identified with the team.



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BB/cr

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MR. OLAH: That's right. I am just asking for maybe a definition of what my friend means by the two words "Trayner team".

MS. CRONK: Q. Well, to resolve my friend's problems, Mrs. Radojewski, do you recall now, it has been suggested in prior evidence that Janet Brownless commenced employment at the Hospital for Sick Children for the first time I believe on August 25th or August 26th, I stand to be corrected.

MR. OLAH: 25th.

MS. CRONK: Q. All right. In my questions to you with reference to the team I am referring to members of the Trayner team as it then existed throughout the months of July and August and the first several weeks of September, that is, Phyllis Trayner, Susan Nelles, Sui Scott and Marianna Christie. Are you clear about that?

A. Yes.

Q. All right. And my question to you was, if towards the end of September you were regarding these deaths as a matter of bad luck and a matter still of coincidence, I am suggesting to you that it was extraordinary bad luck because none of these deaths appeared to be happening when



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any other nursing team save Phyllis Trayner's
appeared to be on duty on the long night shift.

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Is that a fair suggestion?

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THE COMMISSIONER: It is a fair
suggestion in the sense - it may or not be a fair
suggestion but it is certainly argument, is it not.
There probably is a purpose other than argument in
this.

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MS. CRONK: I would like to think so,
sir.

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THE COMMISSIONER: All right.
MS. CRONK: Q. Leaving the question
there, Mrs. Radojewski, my question to you is just
simply this. Did it occur to you at the end of
September that it was anything other than continuing
bad luck that all of these deaths were occurring
in the presence of those members of the same nursing
team all on the long night shift and for the
majority on Ward 4A?

19

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A. I'm sorry, you repeated it
so many times. Just the first three words of what
you said.

21

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Q. Did it occur to you then that
it was anything other than bad luck at that time?

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A. No, it did not occur to me



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that it was anything other than bad luck.

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Q. Did you lend your mind at
all to any other possible explanations?

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A. No, I did not.

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Q. All right. We know as well
that after the meeting on September 26th at which
a number of these deaths were discussed there were
a number of deaths as well that then occurred
during the month of October, the month of November
and through to the month of December. By the time
you left that meeting on September 26th, Mrs.
Radojewski, there had been a number of children who
had been discussed I take it in some detail at those
mortality meetings with the physicians who were
present?

15

A. Yes.

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Q. Did you at that time have
in your own mind any concerns as to the cause of
death of any of the children that had been discussed
at those two meetings?

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A. No I did not.

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Q. To the best of your knowledge,
were any of the other nurses who were in attendance
at those meetings concerned still as to the cause
of death of any of the children who had been



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discussed?

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A. Not that I recall.

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Q. It has been suggested to us

in evidence from another witness, and this, sir,
is found in the evidence of Meredith Frise, Volume
109, that she herself was not satisfied with the
reassurance that was offered at those meetings and
she suggested that there were other nurses as well
who did not appear to have been satisfied. Were
you aware of any suggestion by any of the nurses
on your ward that there was still concern as to the
cause of death of any of those children at the end
of September?

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A. I was not aware that there
was still concern that I can recall being expressed
to me.

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Q. In your own mind were you
concerned, did you have any lingering doubts as
to the cause of death of any of those children when
you left those meetings?

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A. No, I did not have any doubts
when I left those meetings.

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Q. And that I take it extends
both to the case of Antonio Velasquez and from
what you have told us this morning to the case of

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Amber Dawson.

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Q. All right. And then when we come to the month of October, Mrs. Radojewski, I have suggested to you that there were again a number of deaths on those wards during that month. Were any concerns expressed to you by any members of the nursing staff regarding the death of any children during the month of October on either Ward 4A or 4B?

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A. Not that I recall.

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Q. One of the children who did die during that month, Mrs. Radojewski, was Antonio Adamo. He died on the 19th of October. It is my understanding he died on Ward 4A. Do you recall having seen that child prior to his death?

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A. No, I did not see that child.

Q. Do you recall any concerns being expressed to you by any members of the nursing staff with respect to his death?

A. I don't recall.

Q. We have heard in evidence again, sir, from Meredith Frise and this is found in Volume 109 at page 4710 that some of the nurses from Ward 4B felt, as she understood it, that the child had died too quickly and there was concern regarding the cause of his death. Were you aware



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of that perception amongst some of the Ward 4B
nurses?

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A. I can only recollect what I
had read in the Communication Book when I came back.

5

6

Q. All right. You are referring
now to the Ward 4A or 4B Communication Book?

7

8

A. 4B I believe is the one that
had the recording in it.

9

10

Q. All right.

11

A. And I'm sure I would have read
that. It was brought to my attention when I returned
to work.

12

13

Q. There is the recording in
the Ward 4B meeting book as distinct from the
Communication Book, a recording of a meeting which
took place on October 22nd, 1980 amongst some of
the Ward 4B nurses at which this child's death was
discussed. Is that the reference to which you are
referring?

18

19

A. Yes.

20

21

Q. All right. And there is also
recorded in the Ward 4B meeting book a meeting
which occurred on October 23rd, 1980 attended not
only by Ward 4B nurses but as well some Ward 4A
nurses. Were you aware that that meeting had been

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held?

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A. Yes, I was aware.

4

Q. All right. And other than

5

reading what was recorded in the Ward 4B meeting book

6

were you informed by anyone that there had been a

7

meeting held on October 22nd for the purposes of

8

discussing amongst other matters Antonio Adamos'

9

death?

10

A. I remember being informed

11

that there was a meeting but I'm not - I don't

12

recall what it was about at that time.
Q. Did you attend personally
either of those meetings, Mrs. Radojewski?

13

14

A. No, I did not.

15

Q. Were you working at the time;

16

that is October 22nd and 23rd, 1980?

17

A. October 22nd to the 24th I

18

was off ill and I know that I was called about the
evening meeting or about the meeting because there

19

were two of them but I was unable to attend, I was

20

too ill.

21

Q. Do you recall at any time

22

discussing with Mary Costello your counterpart on

23

Ward 4B the matters that had been discussed with

24

the 4B nurses concerning Antonio Adamos' death?

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A. No, I don't recall.

3

Q. Do you recall at any time

4

discussing with any of the Ward 4A nurses who had

5

been in attendance at that October 23rd meeting

6

the concerns that were expressed, if any, regarding

7

Antonio Adamo's death?

8

A. I don't recall, I'm sorry.

9

Q. All right. Could I ask you

10

to look for me if you would please at the Ward 4B

meeting book. Mr. Registrar, it is Exhibit 301.

11

Perhaps I will show you the original,

12

Mrs. Radojewski, it is a little difficult to read.

13

I am showing you the entries for the

14

October 23rd meeting. These are found, sir, at

15

page 8 of the ward meeting book. There is a list

16

of the numbers of persons who attended that meeting.

Do you see the list of names?

17

A. Yes, I do.

18

Q. Can you identify for me please

19

which of those women were 4A nurses as distinct from

Ward 4B nurses?

20

A. Mary Cooney, Gloria, Jane

21

and Phyllis.

22

Q. Gloria?

23

A. Ganassin.

24

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Q. And Jane?

3

A. Excuse me, Jane Partridge.

4

Q. And Phyllis?

5

A. Trayner.

6

Q. Are there any others that are recorded as having been there that were Ward 4A nurses?

8

A. Not that I can see.

9

Q. Thank you. Do you recall any of those three women, that is, the nurses who worked under your supervision on Ward 4A discussing with you at any point the concerns that had been expressed at that meeting on October 23rd?

13

A. I'm sorry, I don't recall.

14

Q. All right. Could I ask you to look at the Ward 4A meeting book as well please. That is at Exhibit 300 beside you. I would ask you to look at the last tab under October 23rd, 1980.

17

18

A. Yes.

19

Q. You have told us that you were away from the Hospital ill on October 23rd. I take it when you did return to the Hospital however one of the things that you would have done would have been to review the ward communication books and the ward meeting books to update yourself

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as to what had occurred in your absence?

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A. Yes.

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A. It is very possible I spoke with Mary Costello about this. I don't recall speaking with anyone else.

12

13

Q. Do you have any recollection of your discussion with Miss Costello at all?

14

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A. No. I know we spoke of it because I looked in 4B's book and realized I would have difficulty reading the writing and I can recall that Mary just told me what had gone on but I don't recall specifics.

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Q. Well, Mrs. Radojewski, it has been suggested here by another witness that two nurses from Ward 4A expressed the view or felt that in some way they might have contributed or been at fault in the death of Antonio Adamo. That is the evidence, of Meredith Frise. The two individuals that she indicated had expressed those concerns were



1
2 Mary Cooney and Phyllis Trayner. Were you ever
3 made aware of the fact - and Mary Cooney was a 4A
4 nurse I believe you told me.

5 A. Yes.

6 Q. As was Phyllis Trayner.

7 A. Yes.

8 Q. Were you ever made aware of
9 the fact that any of your 4A nurses were of the
10 view that some of their actions might in some way
11 contributed to the death of that child?

12 A. I may have been, I just don't
13 recall.

14 Q. All right. The Commission
15 has heard again from a number of witnesses, Mrs.
16 Radojewski, that once Phyllis Trayner and Susan
17 Nelles began working on the same nursing team a
18 conflict arose between the two of them. Were you
19 aware as the head nurse on Ward 4A in the fall of
20 1980 or at any time thereafter of any conflict
21 between Phyllis Trayner and Susan Nelles?

22 A. I am unsure as to the timing
23 but I do recall that there was an episode of a
24 disagreement they had, yes.

25 Q. All right. Can you help me



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please as to what that episode was?

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A. I can't recall who came to see me first, whether it was Susan or Phyllis, but it involved a matter of Susan feeling that Phyllis had called, wanted to call the resuscitation team in and Susan had felt that just the urgent call which we call a 23 was necessary.

Q. I am sorry?

A. We have an urgent call which is a number 23 as opposed to a number 25.

Q. Yes.

A. Which is the resuscitation team.

Q. Yes.

A. And Susan had felt that perhaps at that time a 23 was called -- she wanted to call a 23 and Phyllis said no, that she would call a 25.

Q. Do you recall now what child that incident concerned?

A. No, I'm sorry, I don't.

Q. And other than the occasion of that incident that was discussed with you I take it by either Susan Nelles or Phyllis Trayner you said?



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A. I remember discussing it
with both of them, yes.

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Q. Was there any other incident
of which you were made aware that concerned the
conflict between Phyllis Trayner and Susan Nelles
with respect to resuscitation efforts or the calling
of an arrest team?

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THE COMMISSIONER: Well, I think
we'll just, if there is anyone of which you have
personal knowledge. We have already heard from
people who were present but do you have any personal
knowledge of any conflict between them?

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THE WITNESS: That's the only episode
that I became involved in that I was aware of.

14

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THE COMMISSIONER: I don't know that
you can pursue the other one unless you were
present.

16

17

MS. CRONK: No, that's fine, sir.

18

Q. Did you observe at any time
Mrs. Radojewski, or were you made aware at any time
of an incident where this conflict or this dis-
agreement between the two women appeared to have
affected the nursing care given to any patient on
Ward 4A or 4B?

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A. No.

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Q. Were you made aware of any specific situation where Susan Nelles had apparently overridden a decision by Phyllis Trayner to call in the arrest team?

A. That was the incident that I was speaking to them about.

Q. All right. And that is the only incident you have told us?

A. That's all I am aware of, yes.

THE COMMISSIONER: I don't quite see how, I don't know whether it matters at all, but how could Susan Nelles override Phyllis Trayner's decision. Isn't Phyllis Trayner the senior?

THE WITNESS: She was the team leader at the time, yes.

THE COMMISSIONER: Well, you said that she had ...

MS. CRONK: Yes I did, sir.

THE COMMISSIONER: You assumed that there was an overriding?

MS. CRONK: Well, I'm not sure that I assumed it, sir. I had understood perhaps that that is what Mr. Radojewski had said earlier.

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THE COMMISSIONER: Oh, I thought there was a disagreement about it, but I didn't know - had Susan Nelles prevailed in this disagreement?

THE WITNESS: It was my understanding that a 25 was called.

THE COMMISSIONER: Well then she hadn't prevailed?

THE WITNESS: Yes.

MS. CRONK: Q. Well then, let me put it to you again, Mrs. Radojewski.

Were you made aware of any other instance where it was suggested or where you observed that Susan Nelles had overridden a decision by Phyllis Trayner to call in an arrest team?

THE COMMISSIONER: Well, that wasn't an occasion where she had overridden --

MS. CRONK: I know that, sir.

THE COMMISSIONER: The "other" shouldn't be there.

MS. CRONK: That is why I am suggesting it to her now.

THE COMMISSIONER: I am being very picky. All right.

THE WITNESS: I don't recall.

MS. CRONK: Q. Now, Mrs. Radojewski,



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to be very clear about it, do you recall after the arrest of Susan Nelles being interviewed by the two Crown attorneys who were involved in the preliminary hearing against Susan Nelles, Mr. Robert McGee and Mr. Jerome Wiley?

A. Yes.

Q. I suggest it to you that that interview took place on December 1st, 1981. Would that accord with your recollection?

A. Yes.

Q. All right. Do you recall telling them at that time that you were aware of a situation where Susan Nelles had overridden Phyllis Trayner's decision to call in an arrest team with respect to one of the patients that had died on Ward 4A?

A. I don't know that I would have used the word "overridden", but I told them that there was one occasion where there was disagreement between Phyllis and Susan about calling an arrest.

Q. I am sorry. I suggested to you that it was my understanding that you had indicated that there was an occasion where there had been a disagreement about calling in an arrest team, and Susan Nelles' views had prevailed such that the team was not then called in.



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Are you telling me now that you do not recall having communicated that to Mr. McGee and Mr. Wiley?

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A. The only instance I knew of Phyllis and Susan was that one which I have related.

6

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Q. And that was the situation where you told the Commissioner that Mrs. Trayner's views prevailed and the team was called in?

8

9

A. It was my understanding, yes, that eventually - not "eventually", I don't know if it was eventually - but I know the resuscitation team was called.

10

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Q. As I understood what you said, you do not now know the name of the child involved?

14

15

A. No, I don't, and I don't recall the time either.

16

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Q. Other than that one particular incident, did either Phyllis Trayner or Susan Nelles approach you again indicating or for the purposes of discussing with you the nature of any disagreements they had regarding resuscitation efforts for any particular child?

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A. No, I don't recall any other.

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Q. If Mr. McGee or Mr. Wiley were in due course to attend and give evidence before the



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Commission, Mrs. Radojewski, and were to give evidence that at their meeting with you on December 1st you had indicated that there had been an occasion of which you were aware when Susan Nelles had overridden, if you will, a decision of Phyllis Trayner to call in an arrest team, would you have any reason to disagree with that evidence?

A. I would disagree with the word "overridden" because the ultimate outcome was that the arrest team was called.

Q. Apart from the issue of the disagreements between these two women, Mrs. Radojewski, of which you were made aware, in addition to those problems or those discussions, were there as well in the fall of 1980 discussions concerning the breaking up of the nursing teams on Ward 4A?

MR. ROLAND: Excuse me, Mr. Commissioner, before the witness answers that, as I understand the witness' evidence, she said she only knows of one instance that she was involved with, and I may be getting picky too. Miss Cronk says "these disagreements".

THE COMMISSIONER: Yes.

MR. ROLAND: It seems to me that there is a disagreement that this witness knows about.



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THE COMMISSIONER: Yes. I think the
singular would have been better.

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MS. CRONK: All right. Fine.

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MR. ROLAND: I think the singular is
better.

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MS. CRONK: My friend's point is
entirely appropriate, sir, and I regret the sloppiness
of language.

8

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THE COMMISSIONER: Yes.

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MS. CRONK: Q. Apart from those
matters that we have just discussed --

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12

THE COMMISSIONER: Perhaps Miss Cronk
was expecting there would be more, and that is why she
had prepared the question accordingly.

13

14

MR. ROLAND: I gathered that.

15

THE COMMISSIONER: But the evidence is
one disagreement, yes.

16

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MS. CRONK: Q. Do you recall in the
fall of 1980, Mrs. Radojewski, discussions concerning
the breaking up of the nursing teams on Ward 4A?

18

19

A. I don't really recall that.

20

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Q. Well, in particular, do you recall
in the fall of 1980 or prior thereto any discussion
about the breaking up of the Phyllis Trayner nursing
team?

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A. We must have had some discussion.

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I don't remember who it was or when it was, but I can
4 remember a remark expressed by one of the other team
5 leaders, and that is what leads me to believe that
6 perhaps we did discuss it, but not seriously.

0

Q. Who was the other team leader?

7

A. Marie Mandal.

8

Q. Do you recall what the remark was?

9

A. She felt that she didn't want -

10

wouldn't be happy with any member of the Trayner team
11 on her team because that would mean the jinx would
12 travel with them.

12

Q. By "jinx" are you referring to
13 the number of arrests that were occurring while
14 members of the Phyllis Trayner team were on duty?

15

A. Yes.

16

Q. Was there a perception of which
17 you were aware in the fall of 1980 that that team was
18 jinxed?

18

A. Yes. That was the impression that
19 the staff gave me.

20

Q. We have heard from --

21

MR. OLAH: Excuse me. I am sorry. I
22 take it my friend is still talking about the same
23 members of the team we had discussed earlier, and that

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2 excludes my client?

3 THE COMMISSIONER: Well, frankly I
4 don't know. What time was this? Have you any idea
5 what period this was?

6 THE WITNESS: It would be before March.

7 THE COMMISSIONER: I think we will just
8 have to leave it with you, Mr. Olah, when your time
9 comes to sort it out.

10 MR. OLAH: Thank you.

11 MS. CRONK: Q. So that I am clear,
12 in the fall of 1980 with respect to the members of the
13 team who were then working on Phyllis Trayner's
14 nursing team, was it your understanding that there was
15 a perception afoot that that team was jinxed with
16 respect to the number of deaths that were occurring?

17 A. Yes, that was the impression.

18 Q. And that I take it was because
19 they were on duty when the majority of these deaths
20 occurred?

21 A. Yes.

22 Q. Mrs. Radojewski, we have heard
23 from a number of witnesses, including Carol Brown,
24 Mary Costello, Bertha Bell, just as an example, that
25 there was in the fall of 1980 discussions concerning
the breaking up of the Phyllis Trayner nursing team.



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And most recently we have heard from Meredith Frise during the course of her evidence last week that in particular there had been discussion about breaking up that team.

Is it your evidence today that that was not, I believe your words were, seriously discussed in the fall of 1980?

A. I have - I don't have a recollection of it, and that is why I used the term "seriously discussed".

Q. All right. You told us about a discussion with Marie Mandal. You have told me as well that you did review the Ward 4B meeting book entries for both October 22nd and October 23rd when you had been away from the hospital ill.

A. I reviewed them, but I had difficulty, and I believe I sought Mary Costello's help.

Q. Mary Costello's help to read the entry?

A. Yes.

Q. Do you recall did she provide it?

A. She explained to me I believe what was in it.

Q. All right. Do you recall during



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the discussion with Mary Costello, or alternatively while you yourself were attempting to read the entries for October 22nd and October 23rd, noting the fact that Karen Power was reported as having said that she did not wish her team to be broken up?

A. Yes, I recall that.

Q. You recall observing that?

A. Yes.

Q. Did you know the context in which that discussion had occurred?

A. I don't recall.

Q. Do you recall any discussion about the breaking up of any team other than Phyllis Trayner's team?

A. I don't recall any discussion other than the note that was made about Karen Power.

Q. Is it then - do you recall who first raised the matter at all?

A. No.

Q. To the best of your recollection was Marie Mandal's discussion with you at a time when there had been other discussions in which you participated concerning the merits if any of breaking that team up or was that the first time the issue was raised?



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A. I don't recall. I just recall
the comment being made.

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Q. Ms. Mandal as I understood what
you said indicated she would not - well, will you tell
me exactly what you now recall Ms. Mandal telling you?

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6

7

A. I don't remember her exact words.
That she did not want a member of the Trayner team
working.

8

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Q. All right. And that you have
told me was because of the perception at the time that
the team may have been jinxed with respect to these
deaths?

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A. Yes.

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Q. Was there any resistance which you
can now recall from any other nurses on Wards 4A or
4B to the breaking up of any of the nursing teams, and
in particular Phyllis Trayner's?

16

17

A. I don't recall any resistance.

18

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Q. Do you recall anyone suggesting
to you other than Marie Mandal that she would not wish
any member of Phyllis Trayner's team to serve on her
own?

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THE COMMISSIONER: Excuse me.

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Yes, Miss McIntyre?

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MS. MCINTYRE: As I understand this

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witness' evidence she is saying the only thing she does recall is her discussion with Marie Mandal and reading the entry in the communication book. I therefore don't understand why my friend asks her a whole series of other questions on that topic.

MS. CRONK: Well, sir, I would ask for your indulgence. I think with the next question it will become apparent why I am doing it.

THE COMMISSIONER: Yes. All right. Carry on and we will see what happens.

MS. CRONK: Q. My question to you, Mrs. Radojewski, was whether or not you recalled any nurse other than Marie Mandal indicating to you either that they did not want members of the Phyllis Trayner nursing team working on their team or, alternatively, that they did not want to work on the Phyllis Trayner team?

THE COMMISSIONER: Would it not help if you mentioned the name of the nurse? Would that bring it to her mind? If you have one in mind. Obviously you don't want to, but wouldn't it help the witness to remember?

MS. CRONK: Q. Do you recall that being raised, for example, by Joan MacIntosh?

A. Yes.



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Q. All right. When was that

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discussion?

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A. I don't recall when the discussion
took place.

5

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Q. What did Ms. MacIntosh tell you?

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THE COMMISSIONER: Can we just have the
dramatis personae? Who is Joan MacIntosh? Was she a
nurse I take it?

8

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THE WITNESS: Yes, she was another
registered nurse.

10

11

THE COMMISSIONER: She was on either
team?

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13

THE WITNESS: She was on Susan
Fitzgerald's team at this time.

14

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THE COMMISSIONER: And Fitzgerald was
which?

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THE WITNESS: Another team leader.

17

THE COMMISSIONER: On which ward?

18

THE WITNESS: 4A.

19

THE COMMISSIONER: 4A, yes, I see.

20

MS. CRONK: Q. Just to clear up that
matter, sir: was it your recollection that at the time
this discussion took place between Ms. MacIntosh and
yourself that she was on Susan Fitzgerald's team?

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A. Yes.

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Q. On 4A?

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A. Yes.

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Q. It was my understanding that

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subsequently during the period of time with which we
are concerned Ms. MacIntosh was promoted to the
position of team leader. Is that correct?

7

8

A. Subsequently, yes.

9

Q. But that I take it had not

10

occurred at the time this discussion took place?

11

A. That is right.

12

Q. My question to you, Mrs.

13

Radojewski, was what did Joan MacIntosh tell you with
respect to the Phyllis Trayner team at that time?

14

15

A. She had said something to the

16

effect that she did not feel that she got along with
Phyllis and she preferred not to work with Phyllis

17

because there were times when I had to overlap the

18

teams and there was occasion in order to accommodate

19

requests for time off when team members of another

20

team had to work with a team they were unfamiliar

21

with, and Joan had expressed that she just didn't

22

feel she got along well with Phyllis.

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Q. Was there any other basis for her

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reluctance to work on that team other than what you

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described as her feeling that she didn't get along with her?

A. No. That's the only basis that I was aware of.

Q. All right. Now other than your discussion with Marie Mandal and your discussion with Joan MacIntosh, do you recall any other members of the 4A nursing team or the 4B nursing team expressing to you at any time a reluctance to serve on Phyllis Trayner's nursing team?

A. No.

Q. Similarly do you recall any other nurse on 4A or 4B expressing a reluctance to you to have members of the Phyllis Trayner nursing team work on their own team?

A. Only Marie Mandal in that one instance.

Q. We have heard in fact that the Phyllis Trayner team was not dissolved or split up, if you will, during the fall or spring of 1981. Do you recall any discussions about the matter again arising during the spring of 1981?

A. No, I don't recall.

Q. Can we look then, please, at the deaths which occurred on Wards 4A and 4B during the



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months of October and November of 1980? D'Arcy MacDonald died on December 13, 1980. Again on Ward 4A, at 4:30 in the morning.

As I understand it you worked an eight hour day on December 12th but you were not present and did not work on the ward the day of his death. That is December 13th.

A. Yes.

Q. Do you recall seeing D'Arcy MacDonald the day before he died?

A. I can't recall him.

Q. You have no recollection about the child?

A. No.

Q. Do you recall at any time, Mrs. Radojewski, after the child's death, anyone suggesting to you that digoxin toxicity may have played a part in that child's death?

A. No, I don't recall that.

Q. Could I ask you to look at the tour end reports again if you would, please, page 68. Again looking at the notes which appear to have been made on December 12th during the eight hour day shift, can you tell me are they your notes?

A. Yes, they are.



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Q. That is the day before MacDonald

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died? He died on the long night shift that night?

4

A. Yes.

5

Q. Would it be fair of me to

6

suggest on the basis of your description of his

7

condition on December 12th that he --

8

THE COMMISSIONER: That is on the

9

reverse side, is it?

10

MS. CRONK: Yes, sir, it is.

11

THE COMMISSIONER: All right.

12

MS. CRONK: Q. -- that you regarded

him as being in a relatively stable condition when you
completed your shift?

13

A. Yes.

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Radojewski, dr.ex.
(Cronk)

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Q. Is there anything in that tour end report where either the evening shift or in your own day shift note which suggests to you that there was a deterioration in his condition prior to the long night shift?

A. No.

Q. Do you recall any concern being expressed to you by anyone, Mrs. Radojewski, after his death, as to why he had died?

A. No, I don't recall.

Q. Are you aware of any procedure or guideline which applied during this period on Ward 4A for the reporting of a child's death to the coroner?

A. Could you repeat that please?

Q. Are you aware of any guidelines, policy or practice which applied on Ward 4A/B during this nine month period of time for the reporting of the death to the coroner?

A. Only the usual, there was nothing-- I'm not sure I understand your question.

Q. What do you mean by the usual? When, as you understood it, would deaths on those wards be reported to the coroner?



Radojewski
dr. ex. (Cronk)

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A. If there was a death occurring
in less than 24 hours after the child had been admitted;
if there were unusual circumstances.

5

Q. Anything else?

6

A. That is all I can remember right
now.

7

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11

Q. Do you recall at any time after
D'Arcy MacDonald's death any suggestion being made,
in your presence, or of which you are aware, as to
whether or not that child's death should be reported
to the coroner?

12

A. No, I don't recall.

13

14

15

16

Q. To assist you with that, it is
my understanding that D'Arcy MacDonald was admitted
to the hospital on December 12th in the mid-afternoon
at approximately 1:52 p.m., does that accord with
your recollection, or would you like to see the chart?

17

18

THE COMMISSIONER: It is what comes
after that, Ms. Cronk.

19

20

MS. CRONK: We know, sir, that on
occasion the admission times noted in the charts have
been suggested to be in error.

21

22

THE COMMISSIONER: Yes.

23

24

25

MS. CRONK: And if Mrs. Radojewski has
any information different from that, I would be



3
1
2 grateful for it.

3 THE WITNESS: I'm sorry, I don't,
4 because I don't remember this child much at all.

5 THE COMMISSIONER: So I take it the
6 date of death was the 13th, which is within 24 hours.

7 MS. CRONK: Yes, it is, sir, at 4:30
8 in the morning.

9 THE COMMISSIONER: Yes, all right.

10 Q. As I have understood what you have
11 said, Mrs. Radojewski, apart from having the benefit
12 now of the notes that you made on the tour end report,
13 you have very little recollection of this child at
14 all, is that correct?

15 A. That's right.

16 Q. Do you recall at any time having
17 any discussions with any of the residents who had
18 been on duty at the time of his death with respect
19 to the circumstances of his death, or his terminal
20 events?

21 A. No, I don't recall.

22 MS. CRONK: Mr. Registrar, could you
23 show Mrs. Radojewski, please, Exhibit 71 which is
24 D'Arcy MacDonald's medical chart.

25 Q. I would ask you to turn, if
you would, Mrs. Radojewski, to page 58 of the chart,



1

2

Each page is numbered in the top right hand corner.

3

A. I don't think I have a page 58,

4

oh, I'm sorry, I do.

5

Q. Do you have it?

6

A. Yes.

7

Q. I confess, Mrs. Radojewski, some

8

difficulty in deciphering the signature for the note

9

made by the 4B resident who had been on call at the

10

time the child died, it was made obviously on

11

December 13th, the night that he died, do you see that?

12

A. Yes.

13

Q. Can you help me as to whose
signature it is?

14

A. I'm sorry, I can't.

15

Q. You will see mid-way down

16

through a description of the child's arrest and the

17

events that took place following the child's arrest,

18

the recording of an impression, do you see that?

19

A. Yes.

20

Q. It is part of what I take to be

21

a differential diagnosis at that point there is

22

mention of digoxin toxicity; do you see that?

23

A. Yes.

24

Q. That is included with a reference

25

to vagal reflex, do you see that?



1

2

A. Yes.

3

Q. And reference to arrhythmias?

4

A. Yes.

5

Q. And finally reference to a poor
conduction system.

6

A. Yes.

7

Q. To the best of your recollection,

8

Mrs. Radojewski, were you made aware at any time

9

by any members of the nursing staff who had been

10

on the long night nursing shift that night that

11

D'Arcy MacDonald died, that one of the residents who

12

had been in attendance during his arrest and at the

13

time that he was pronounced dead, had considered

14

as a possible explanation as part of a differential

15

diagnosis the possibility of digoxin toxicity with that
child.

16

A. I don't recall anything about

17

D'Arcy MacDonald.

18

Q. Including that?

19

A. Yes.

20

Q. Do you recall as well, I assume,

21

that there was another child who died on the ward

22

within a matter of days from the date that D'Arcy

23

MacDonald died and that was Real Gosselin who died

24

on the 18th of December. Do you recall seeing this

25



1
2 child prior to his death?

3 A. Yes.

4 Q. It is my understanding that the
5 child was -- I am sorry, that you worked on
6 December 17th an 8 hour day and again on
7 December 18th for an 8 hour day, and he died during
8 the course of the long night shift on December 17th.
9 Do you recall what the child's condition was when
10 you last saw him?

11 A. He was very ill looking, I
12 can remember seeing him in an Isolette, and I
13 remember meeting the mother in the morning when I
14 came on duty.

15 Q. Was that on December 17th, or
16 prior to that?

17 A. The morning of December 17th.

18 Q. Can I ask you again if you will,
19 please, to turn to the tour end report for Real
20 Gosselin, page 7, do you have that?

21 A. Yes.

22 Q. These are the entries for
23 December 17th, and I note that on the prior page the
24 entries for the day shift on December 16th, there
25 is a notation that Real Gosselin was expected to be
admitted on the ward and that he was expected to be



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arriving from St. Boniface in Winnipeg that evening,
do you see that?

A. Yes.

Q. Do I take it then at the end of
the day shift on December 16th the child had not
yet been admitted?

A. That's right.

Q. And then on December 17th
during the day, are those your notes of his condition
at that time?

A. Yes.

Q. Is there anything in that
note which having had the time now to review it
suggests to you that you perceived at the time his
condition to be critical?

A. I can remember perceiving him
as being of some risk, he was on I.V. prostaglandin
and with a diagnosis of a severe coarct.

Q. Did you regard him to be at
imminent risk of dying when you left work that day,
Mrs. Radojewski?

A. Not at imminent risk, but at
risk.

Q. Of dying?

A. Of arresting.



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Q. As I understand it at that time, looking at the front sheet of the tour end report on December 17th, the child was neither on shared nursing care nor on constant nursing care.

6

A. Right.

7

8

9

10

Q. If we examine the evening note from the nursing shift, that is, up until 11:00 at night, is there anything in that note which suggests to you that the child's condition either had worsened, or had become very grave indeed?

11

12

13

14

A. There had been some -- by reading that there had been some deterioration in that he required I.V. lasix and he was having apneic spells which could be due to the prostaglandin.

15

16

17

Q. I take it inasmuch as you were not at work on the long night shift that the earliest time you would have learned of his death was the very next day, December 18th.

18

A. Yes.

19

20

Q. Do you recall at that time whether or not you regarded his death as being unusual?

21

22

23

24

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A. His death was explainable to me.

Q. Was it explainable to you on the basis of what you understood his medical condition to be?



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A. Yes.

Q. It is my understanding that he was scheduled for surgery on the morning of December 18th, is that correct?

A. Yes.

Q. He died, of course, on the long night shift before he had a chance to get to surgery.

A. Yes.

Q. Was there in your mind on December 17th, when you left work that day, any expectation that he might not live long enough to reach surgery?

A. No.

Q. So to that extent was there some degree of surprise in your mind when you learned of his death?

A. Yes, some degree.

Q. When you say it was explainable, what did you understand to be the expressed explanation for his death, if there was any, from the physicians connected with that unit?

A. He was a very severe coarct and in my experience we had referred to it in the newborn period as the coarctation syndrome, and we certainly were on the lookout for these babies. By



1
2 that I mean we tended to, I guess, assess them a
3 little more closely because in my experience they
4 had a habit of going sour very quickly.

5 Q. By going sour, you mean running
6 into difficulties?

7 A. Yes.

8 Q. Perhaps arresting?

9 A. Yes, running into difficulties.

10 Q. When you were still at the
11 hospital on December 17th, had the child's
12 prostaglandin therapy been commenced at that point,
13 as best as you can now recall it?

14 A. By virtue of just reading the
15 tour end report, I can't recall on my own, but
16 the tour end report tells me it was.

17 Q. Do you recall now yourself
18 having made any observation as to his response
19 to that therapy before you left work that day?

20 A. I don't recall.

21 Q. Did you at any point discuss
22 the death of this child with Dr. Freedom?

23 A. I don't recall.

24 Q. Were there any concerns expressed
25 to you by any members of the nursing staff, or by
any members of the medical staff, following his death



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as to why he had died at the time that he did die?

3

A. I don't recall that there was.

4

Q. prior to testifying here, Mrs.

5

Radojewski, were you aware of the fact that Dr.

6

Freedom on December 18th wrote to the referring

7

physician in Winnipeg and expressed the view with

8

respect to Real Gosselin that at that time he did not

9

really have a good explanation for the child's death.

10

Prior to testifying here were you aware that that

had happened?

11

MR. ROLAND: Sir, I am not sure what

12

the point of the question is. Of course, that

13

evidence has gone in through --

14

THE COMMISSIONER: Through Dr. Freedom,
yes.

15

MR. ROLAND: And she could have read

16

this in the newspapers and she may have seen it. The

17

point is that the child is dead, the record is on

18

the ward and Dr. Freedom has explained that letter.

19

THE COMMISSIONER: The only conceivable--
if she had been aware that there was some doubt in

20

Dr. Freedom's mind at the time it might have been of

21

some interest, but I take it you did not have that

22

awareness.

23

THE WITNESS: No, I was not aware of

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that.

MR. ROLAND: She has already said she didn't discuss it with Dr. Freedom.

MS. CRONK: In my submission, sir, and in fairness I have accepted the objections of my friend this morning and many of them were quite proper, but this one I have a problem with. It seems to me that I am perfectly entitled to probe with Mrs. Radojewski whether or not as a result of Dr. Freedom's immediate reaction to the death and any correspondence he may have had with the referring physician, that sparked any discussions, or any observations of which she heard concerning this child's response to prostaglandin therapy, that was merely my intent. She has now told me she didn't know of that fact so it couldn't possibly have led to anything in her mind.

THE COMMISSIONER: All right. We can leave it, then, I guess.

MS. CRONK: May I suggest that we leave it indeed for our luncheon break at this time.

THE COMMISSIONER: Yes, all right. We will be back at a quarter past 2.

---Luncheon recess.



BmB.jc
AA

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--- Upon resuming:

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THE COMMISSIONER: Yes, Miss Cronk?

4

MS. CRONK: Thank you, sir.

5

Q. Mrs. Radojewski, before the

6

luncheon break we were discussing the death of Real
Gosselin and the circumstances surrounding his death.

7

There are just one or two other matters with respect
to that child.

8

9

Do you recall at any time following

10

that child's death anyone suggesting to you or to

11

anyone else about which you heard that digoxin may

12

have contributed in any way to the child's death?

13

A. No, I don't recall.

14

Q. Do you recall any discussion

15

after his death as to whether or not his death should
be reported to the coroner?

16

A. No, I don't recall any discussion.

17

Q. To your knowledge, was that done?

18

A. No, to my knowledge I have no

19

idea.

20

Q. You will recall that we spoke

21

this morning as well about Antonio Velasquez and you
told me as I understood it, that you learned of his

22

death for the first time on August 25th when you went

23

back to work having been absent on the 24th. Do I

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have that correctly?

A. Yes.

Q. And you told me as I heard it this morning on that day when you learned of his death you discussed it with Phyllis Trayner, to the best of your recollection you thought it was on August 25th. Is that correct?

A. Yes.

Q. And she told you at that time you have said about the two doses of the Narcan that had been administered to the child during the course of his arrest?

A. Yes.

Q. And she told you at that time as well I believe you said that she was concerned as to why the child had died.

A. There were some concerns raised.

Q. During that discussion with Mrs. Trayner?

A. I believe it was that discussion.

Q. Did you speak to Mrs. Trayner about this at the Hospital?

A. Yes, we were in uniform.

Q. You don't recall speaking to her about it by telephone, for example?



AA.3

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A. No.

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Q. All right. Could I ask you

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to look if you would please at Exhibit 32C.

5

Mr. Registrar?

6

I would ask you to turn when you have

7

the exhibit, Mrs. Radojewski, to Tab 89 and to page

8

118 and 119. This is the assignment book for Ward 4A

during August, 1980; page 118 and 119, do you have that?

9

A. 118 and 119?

10

Q. That's right.

11

A. Yes.

12

Q. I would ask you to look at the

13

nursing assignments that are recorded that day, it is

for August 25th, the Monday, is that correct?

14

A. Yes.

15

Q. And I suggest to you that

16

Phyllis Trayner was not recorded as having worked on

17

the ward on the 25th of August, is that correct?

18

A. Yes.

19

Q. Would you turn please to the

20

next page, August 26th. I suggest to you that Phyllis

21

Trayner is recorded as having been ill that day and

22

she did not work, be it on the day shift, the evening

shift or the night shift on the 26th of August?

23

A. Yes.

24

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Q. Is that correct?

A. Yes.

Q. Would you turn to the next page please, August 27th. Again, I suggest that Phyllis Trayner did not work because she was ill any time on that day on the ward, is that correct?

A. Yes.

Q. Would you turn to the next page, August 28th. Is there any indication that she worked on the 28th of August?

A. Not that I - no, there isn't any indication.

Q. August 29th, any indication that she worked that day?

A. No, there isn't any indication.

Q. It is my understanding, to help you, Mrs. Radojewski, that Mrs. Trayner did not return to work until September 25th, that she was gone and absent from the Hospital either due to illness or due to holidays from the 25th of August through for a month until the 25th of September?

A. Yes.

Q. All right. That is reflected by the 4A WIN sheets. Bearing that in mind, can you help me please as to who told you first about the



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death of Antonio Velasquez and who told you about the doses of Narcan that had been given to him during the course of his arrest?

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A. In my mind I thought it was Phyllis Trayner and I don't, I can't recall then who it is.

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Q. It seems clear does it not that you could not have discussed it with her at the Hospital during the period August 25th through to September 25th unless she came into the Hospital on an occasion when she was not required to be working; that's clear, isn't it?

13

14

15

A. Yes.

16

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Q. All right. Do you recall her having come in during that month any day when she was not required to work?

20

21

22

23

24

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A. No, I don't recall.

Q. Do you have any recollection at all then as to who it was that you held this discussion with the morning after Velasquez' death?

A. If it wasn't Phyllis then it must have been someone in uniform because I know we were in uniform and it was morning.

Q. Well, do you recall with certainty in your own mind today whether or not it



AA.6

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was a nurse who had worked the long night shift when
Antonio Velasquez died?

3

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A. Yes, it was a nurse who worked
the long night shift.

5

6

Q. But you don't recall who it was?

7

A. No.

8

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Q. Could I ask you to consider
now if you would, please, Mrs. Radojewski, the death
of Stephanie Lombardo. She died, as you may recall,
on December 23rd, 1980 at approximately 4:20 in the
morning. It is my understanding that you worked a
12-hour day shift on December 22nd and December 23rd,
is that correct?

13

A. Yes.

14

15

16

17

Q. Okay. Can you help me, just
out of curiosity, I'm not sure that much turns on
this, why you would have been working a 12-hour day
shift on those days when you normally worked an 8?

18

19

20

21

A. We did a lot of rearranging
of time around Christmas in order to afford the staff
time off for visiting their families. We had many
from out of town and I was doing the job of team
leader and nurse in charge for those two days.

22

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Q. We have heard in prior evidence
that the wards in fact were merged, if I can describe



AA.7

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it that way, for the Christmas period, and that
commenced on December 24th. Does that accord with
your recollection?

4

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A. Yes.

6

7

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Q. And during that period,
commencing on December 24th, they were treated as one
with one nurse delegated as being in charge of both
Ward 4A and 4B?

9

A. Yes.

10

11

Q. And that was not I take it in
effect on December 22nd or December 23rd?

12

A. No.

13

14

Q. Do you recall seeing Stephanie
Lombardo at any time on December 22nd, the day before
she died?

15

A. I can't recall this child.

16

17

18

Q. All right. Once again, could
I ask you to turn to the tour end reports if you
will please, page 71. Do you have that?

19

A. Yes.

20

21

Q. Is the entry for the day shift
on December 22nd yours?

22

A. Yes, it is.

23

24

25

Q. It would appear that Stephanie
Lombardo was transferred from the Intensive Care Unit



AA.8

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back to Ward 4A at 11:30 on the morning of December
22nd, according to your notes; is that correct?

3

4

A. Yes.

5

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Q. Would it be fair of me to
suggest on the basis of the description that is
contained in the day note that you made that it is
not a description of a critically ill infant at that
stage?

9

10

11

A. Yes, that's right.

Q. She does not appear then to have
been on shared care nursing or constant care nursing?

12

13

14

15

A. It doesn't appear to be, no.

Q. And there is nothing in the
evening shift note that appears to help us very much;
in fact, there is only one word and I have some
difficulty reading it. Can you assist me?

16

17

A. It looks like it could be a
short form for satisfactory.

18

19

20

Q. All right. And then we come
to the long night note, the very first entry we see
is that the child's condition is recorded as having
been stable.

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A. Yes.

Q. And then the very next note
is that she arrested and she died. Do you see that?



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A. Yes.

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Q. When you left work on December 22nd having completed on that day a 12-hour day shift and bearing in mind the note that you did make on the tour end report, can you help me as to whether or not Stephanie Lombardo was regarded by the nursing staff to be in critical or grave condition at that time?

A. On the basis of the note on the tour end report I would have to say it doesn't appear that she was of a critical nature at the time.

Q. All right. It is my understanding, Mrs. Radojewski, that Stephanie Lombardo on December 22nd was receiving by way of medication only one drug and that is Heparin and that she was receiving that via a sage pump. Does that accord with your recollection or do you know what medication she was receiving the day before her death?

A. Having read this and reviewed her chart she was getting the Heparin.

Q. All right. Was she prescribed as having received any other medication on the 22nd of December?

A. Not that I saw on her chart, no.

Q. When would a sage pump be used, Mrs. Radojewski, on Ward 4A instead of a normal intravenous apparatus?



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A. When you were using a drug such as Heparin, which could be potentially lethal if the dose was not run according to what the doctor had ordered, that is a very small dose, and a sage pump accorded as the ability to administer to the child from .5 of a millilitre per hour to 5 mls per hour, which is a very small dose and as far as I know we are unable to do that by hand by the manual control of the regular IV setup.

Q. Do I take it then that the use of the sage pump had two advantages; the first being that it permitted the administration of a very small dose of medication?

A. Yes.

Q. And secondly it permitted it to be administered, if it was appropriate, in a very slow fashion?

A. Yes.

Q. And you have told us, I take it, the rates that you have described to be the minimum and maximum flow rates for a sage pump?

A. Yes.

Q. And they are you have said .5 millilitres to 5 millilitres per hour?

A. I believe the top number was 5, yes.



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Q. All right. Can you describe for us very briefly because we have not heard this from any other witness how a sage pump in fact is connected to a child, what physically does it look like when it is set up for a child?

A. It's a green box about this long (indicating).

THE COMMISSIONER: Can you ...

MS. CRONK: 7 or 8 inches, Mrs. Radojewski?

THE WITNESS: Pardon?

MS. CRONK: Q. 7 or 8 inches, 10 inches, 12 inches?

THE COMMISSIONER: It looks less than that to me.

THE WITNESS: It's not very big.

THE COMMISSIONER: 3 or 4 inches.

MS. CRONK: Well, that's a big 3 or 4 inches, sir. It's been a bad day but that is a big 3 or 4 inches.

THE WITNESS: And on it we could use either a 20 ml syringe or the size said 50 on the actual apparatus on the sage pump but we used 60 ml syringes. The medication would be drawn up according to the dilution that was ordered into either the



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20 ml syringe or the 50 - or the 60, I'm sorry, and a very fine tubing was then attached to the end of the syringe instead of the needle and that fine tubing was attached to the little infusion set that actually did go into the vein of the child.

Q. Do I have it then that a 20 cc. or a 60 cc. syringe would actually be attached to the pump itself?

A. Yes.

Q. All right. And it was that vehicle, that syringe, that was used to contain the medication that was to be administered to the patient?

A. Yes.

Q. And attached to the syringe instead of a needle as one might find on a normal IV apparatus there was the tubing that you have described?

A. Yes.

Q. And did that run then directly from the syringe and the pump to the vein of the patient where the medication was intended to enter the body of the child?

A. Yes.

Q. Was that tubing the same as the IV tubing that we would see on a normal IV apparatus?



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A. No, it was much finer. It was a fairly long length of tubing. I can't recall the exact length but in total it only held about 4 millilitres of solution.

Q. Over the total length of the tubing?

A. Yes.

Q. And were there ports of entry on that stretch of tubing which would permit a medication to be injected into the tubing other than through the syringe which was attached to the pump?

A. There could be. There were not actual injection sites on the tubing but an injection site could be attached where the syringe and the tubing were attached. We had disposable injection sites that could be attached.

Q. We have heard something as well about the use of an Ivac on certain patients on the ward. Can you tell me please if you have for the sage pump what the minimum and maximum flow rates are for medication when an Ivac is being used?

A. An Ivac, the minimum flow rate is 1 ml per hour and the maximum is 99 mls per hour.

THE COMMISSIONER: I'm sorry, minimum flow rate is what, please?



AA.14

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THE WITNESS: Excuse me, 1 millilitre.

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THE COMMISSIONER: Per hour?

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THE WITNESS: Per hour and the maximum
is 99 millilitres per hour.

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MS. CRONK: Q. And when would an Ivac
be used in connection with the patient as opposed to
a normal IV apparatus?

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A. Again, when you wanted to make
absolutely sure that you had the proper infusion
rate that was ordered, if you had a very small rate
at 2 mls per hour or something that would be difficult
to control manually.

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Q. Again an Ivac had the advantage of permitting administration of small doses of medication?

A. Small or large because it went as high as 99.

Q. All right. And again it had the advantage if it was desirable that it could be administered in a slow fashion?

A. Yes.

Q. Can you tell me, please, what the minimum flow rate is on a standard IV apparatus that was then used on those wards?

A. That is difficult to assess. I would think that safely you could manually control it at 4 to 5 millilitres per hour.

Q. I take it then that if the doctor's order was such that a quantity of a drug less than 4 millilitres were to be administered, one would have used either a Sage pump or an Ivac to accomplish that?

A. It is preferable, yes.

Q. Well, could it in fact be done on a standard IV at all if it was less than 4 millilitres?

A. I don't think it could be done



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safely, no.

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Q. All right. And in terms of controlling the flow rate on a standard IV apparatus, we have heard that you could do that by virtue of a control mechanism that was located on the buretrol?

A. It was located along the length of the tubing below the buretrol.

Q. All right. And it was by use of that control mechanism that one determined the actual rate at which the medication would flow through to the child?

A. Yes.

Q. Were there situations as well where you would have both a Sage pump apparatus and a normal IV apparatus in use with a particular patient at the same moment in time?

A. Yes, you could have.

Q. And if that were the case would there be more than one injection site to the body of the patient in use or would it be simply one vein?

A. It would be one vein.

Q. And in both mechanisms then, the normal IV tubing with a needle attached, and the Sage pump tubing, would feed into the same vein at the same time?



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A. Yes.

MS. CRONK: Mr. Registrar, could you show Mrs. Radojewski, please, Stephanie Lombardo's medical chart, which is Exhibit 78?

Q. I ask you to turn first to page 90 if you would of the doctor's orders for December 22.

Do you have that?

A. Yes, I do.

Q. Am I correct in suggesting that an order was made by Dr. Lichtman on the 22nd of December that heparin was to be run at a rate of 1 millilitre per hour for Stephanie Lombardo?

A. Yes.

Q. And based on the minimum flow rates that you have described to us that could have been done using either a Sage pump or a normal IV apparatus by utilizing an Ivac; is that correct?

A. Yes.

Q. Could you turn now, please, to page 48 of the chart - sorry, to page 40.

A. Yes.

Q. I would ask you to look if you would, please, at the nursing note which appears at the bottom of the page and the date and time of that



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entry may be difficult to read on your copy but I could tell you from the original and from prior evidence that that is a nursing note for, again, December 22nd, and it appears, and I would refer you to the bottom portion of the entry --

THE COMMISSIONER: I am sorry, Miss Cronk, I have lost the page.

MS. CRONK: Sorry, sir. Page 40.

THE COMMISSIONER: Thank you.

MS. CRONK: Q. I would refer you to the bottom portion of that nursing note that begins with "output".

A. Yes.

Q. "Voiding adequate amount", and then in the next line it is indicated that the heparin was infusing on a Sage pump at 1 cc per hour into a cutdown in the right leg.

Do you see that?

A. Yes.

Q. That suggests, does it not, that the child was on a Sage pump as opposed to using an Ivac at that particular time?

A. Yes.

Q. And as well, the injection site or the vein that was being utilized was in the right



BB 5

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leg?

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A. Yes.

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Q. I would ask you to turn now to page 41 if you will, please. There are two notes on the page.

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The first note is a medical record and the second appears to be the nursing note for December 23rd, for the long night shift, commencing at 1900 hours through to 3:30 in the morning.

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There is an indication there that the heparin was infusing well. Do you see that?

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A. Yes.

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Q. There is no suggestion that the Sage pump had been - use of the Sage pump had been discontinued in favour of some other mechanism?

15

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A. No, there is no suggestion.

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Q. Did you at any time on December 22nd during the course of that 12 hour shift, Mrs. Radojewski, see anyone administering any medication to Stephanie Lombardo via the Sage pump?

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A. I don't recall Stephanie Lombardo.

22

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Q. Well I take it then you don't recall --

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A. I don't recall.



BB 6

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Q. -- one way or the other whether
you did?

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A. No.

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Q. Do you recall one way or the
other whether at any time on that day you saw a
standard IV apparatus connected and running with
Stephanie Lombardo as opposed to a Sage pump?

8

A. I don't recall.

9

Q. One way or the other?

10

A. That's right.

11

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Q. Do you have any recollection one
way or another as having seen anyone using a syringe
in connection with the Sage pump in that child's room,
or indicating to you that the syringe needed changing
on the Sage pump?

15

A. I don't recall.

16

Q. One way or the other?

17

A. That is right.

18

19

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21

Q. Was it ever suggested to you at
any time, Mrs. Radojewski, or ever reported to you
that a medication error had occurred with respect to
Stephanie Lombardo while she was a patient on Ward 4A?

22

A. Not that I recall.

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Q. All right. I take it had a
medication error occurred, that is something you have



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told us you would expect to have been brought to your attention, having regard to the fact that she was a patient on your ward?

A. Yes.

Q. Assuming that it was detected or known to have occurred?

A. Yes.

Q. Who on Wards 4A/4B as amongst registered nurses, physicians and registered nursing assistants had the authority to both start and to deal with a Sage pump in respect of any particular patient?

A. Physicians and registered nurses.

Q. All right. Do I take it from that that registered nursing assistants were not authorized to either start a Sage pump or to stop one?

A. That's right.

Q. Were they authorized to change a syringe or to insert a new syringe on a Sage pump?

A. Not registered nursing assistants, no.

Q. Registered nurses were?

A. Yes.

Q. Was it ever suggested to you as best as you can now recall it with respect to



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Stephanie Lombardo that there was any concern amongst members of the nursing staff as to why the child had died?

A. Not that I recall.

Q. And finally, was it ever suggested to you as best as you can now recall it by anyone at any time that digoxin toxicity may have played a part in that child's death?

A. Not that I recall.

Q. There was another child who died in December on Ward 4A again. That is Jesse Belanger who died at approximately 8:10 in the evening on December 28th.

I take it that is at a time when the wards were merged for the Christmas holidays?

A. Yes.

Q. It is my understanding that you worked - did not work on December 27th nor on December 28th, but you came in to work for a 12 hour shift during the day on December 29th. Is that correct?

A. Yes.

Q. Do you recall seeing Jesse Belanger at any time prior to his death on the wards?

A. I have no recollection of this baby either.



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Q. Again the same thing. Could I ask you to look at the chart if you would, and perhaps you will be able to assist me - that is Exhibit 79, Mr. Registrar.

If you would turn, please, to page 61 of his chart. I would refer you to the note which appears to be a nursing note at the bottom of page 61. It is dated December 28, 1980, between the hours of 1400 and 1930.

A. Yes.

Q. Do you see that?

A. Yes.

Q. It suggests that the child was transferred or at least received from Ward 7G on Ward 4B during those hours. Do you see that?

A. Yes.

Q. Ward 7G was the neonatal unit in the hospital?

A. Yes, it was.

Q. There is also an indication that the child at that time was being fed by a nasogastric tube?

A. Yes.

Q. And that his IV was infusing well?



BB 10

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A. Yes.

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Q. Which suggests that a normal IV apparatus was connected to the child?

5

A. Yes.

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Q. Could I ask you now to turn to page 125?

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THE COMMISSIONER: I take it the IV - the IV is a method of feeding the children as well, is it not?

10

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THE WITNESS: It is a method of administering fluid.

12

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THE COMMISSIONER: In this particular case the IV was not being used for that purpose; is that right?

14

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THE WITNESS: I assume the IV may have been as a supplement for the fluids he was getting or for medication.

17

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THE COMMISSIONER: Is it usual to have both?

19

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THE WITNESS: A nasogastric tube and intravenous?

21

THE COMMISSIONER: Yes.

22

THE WITNESS: Yes.

23

THE COMMISSIONER: Quite often that happens?

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THE WITNESS: It is fairly common.

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MS. CRONK: Q. At any given time I

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take it, though, you could only have either a fluid

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meant by way of a feeding sustenance for the child or

6

medication flowing through the IV tubing. You

7

obviously couldn't have both at the same time.

8

A. Would you repeat that for me?

9

Sorry. It is just your term.

10

Q. You have suggested that the IV

11

could be used for the purposes of feeding the child

even though a nasogastric tube was utilized as well.

12

A. Yes, but we didn't use your

13

standard type formula. By feeding I mean the intra-

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venous fluid may have contained certain nutrients and

we refer to it as feeding.

15

Q. Thank you. And you could insert

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into the IV fluid as well a medication that the child

17

was to receive?

18

A. Yes.

19

Q. Could you turn with me now,

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please, to page 125. This is a portion of the doctor's

21

orders. About half way down the doctor's orders there

22

is a reference to heparin infusion and the initials

DC.

23

Do I have it correctly that that is an

24

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BB 11



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2 order to discontinue heparin infusion at 2 cc's an
3 hour? That was to cease?

4 A. It appears to be, yes.

5 Q. Can you help me as to what the
6 latter part of that order refers to?

7 A. 50 units of heparin per hour.

8 Q. And was the doctor who made this
9 order - it appears - I want to suggest Dr. Freedom
10 but it may be Friedman - was the doctor ordering a
11 reduced amount of heparin to be provided for the
12 child or was he ordering that it be discontinued
entirely?

13 A. Reading that as it is, I would
14 say that there is some confusion. It helps to know
15 the doctor that is writing the order whether that is
16 his form for decrease or discontinue.

17 Q. Do you recognize the signature
on that doctor's order?

18 A. No, I don't.

19 Q. Could I ask you to turn now if
20 you would, please, to page 61 again? There is also
21 a similar note with respect to heparin that dates
22 from the day before, December 27th.

23 Can you help me as to what that
24 reference refers to as to heparin that the child was
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to receive?

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A. Receiving a hundred units of
heparin per hour and with the arrow pointing down
I believe it means to decrease to 50 units heparin
per hour.

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Q. Does that appear to correspond
to the doctor's order that we just looked at?

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A. Yes.

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Q. All right. So it would be fair
to suggest on the basis of that order, and I can tell
you I have not been able to locate a subsequent one
ordering the full discontinuance of the heparin ,
that it was continued but at a lower rate or at least
a lower volume than previously had been in place?

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A. Yes.

Q. Do you recall after Jesse
Belanger's death, Mrs. Radojewski, any concerns being
expressed to you by any members of the nursing staff
regarding the cause of that child's death?

A. No, I don't recall.

Q. One way or the other?

A. That's right.

Q. Do you recall one way or the
other whether it was ever suggested to you at any time
by anyone that a medication error could have occurred



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with respect to that child while he was on Ward 4B?

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A. I don't recall.

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Q. I would ask you to turn to page 64 while you still have the chart open. You will see on that page, Mrs. Radojewski, the nursing notes for December 28th, 1980, and I draw your attention to the one that appears on the bottom of the page commencing at 1930. Do you see that?

9

A. Yes.

10

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Q. It suggests that a cardiac arrest was called at 7:30 in the evening. Is that correct?

13

A. Yes.

14

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Q. And if you look to the note which appears immediately prior to it, again a nursing note (it appears to have been by Miss Reaper). It suggests at 6:30 the child's apex was noted to be irregular, his colour became somewhat dusky, his respirations were very, very shallow - sorry, very shallow.

19

Do you see that?

20

A. Yes.

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Q. So it would appear that the child developed difficulty at 6:30; an arrest was called at 7:30 and then if we continue on through the notes I can tell you that the child was pronounced dead at



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approximately 8:10 in the evening.

3

That would mean I suggest, Mrs.

4

Radojewski, that the arrest if called at 7:30 was
called very shortly after shift change?

5

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A. Yes.

7

Q. That evening?

8

A. Yes.

9

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Q. And the long day nurses would
still be there, would they not, giving report to the
new nursing staff coming in?

11

A. They could be, yes.

12

Q. All right.

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THE COMMISSIONER: I am not - I don't
know, but I am just reading this. 1830 - you see it
is all 1830, under Miss Reaper's note cardiac arrest
was called and then the later note from Dr. Costigan
is 7:30. I am not too sure that that 7:30 couldn't
have been the time that Dr. Costigan made his note
and the arrest may have been at 6:30. I don't know.
Is it clear to you? If it is clear to you --

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MS. CRONK: Well, sir, I suggest
perhaps this is the only material point at the moment
for the purposes of my questions that the earliest
time at which the child is recorded as having gotten
into difficulty was 6:30 that night and at some time



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Radojewski, dr.ex.
(Cronk)

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thereafter, perhaps at 7:30, perhaps a little earlier,
an arrest was called in fact. A cardiac arrest.

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MR. ROLAND: Sir, if you turn to page 66 you will note it says drugs administered during arrest.

THE COMMISSIONER: It says 7:30 -- arrest, you are quite right.

MS. CRONK: I am grateful, Mr. Roland. I think the point only, sir, at the moment I think Mrs. Radojewski has agreed with this interpretation of the progress notes, that the earliest time the child appears to have been in difficulty was at 6:30 that evening.

Q. I asked you a moment ago, Mrs. Radojewski, if the arrest was called at 7:30, whether that would necessarily mean that it was called while the long day nurses were on duty, and I think your answer was they might be, is that right?

A. Yes.

Q. I had understood that the long night nursing shift commenced at 7:15 p.m. in the evening.

A. Yes.

Q. And that the long day nursing shift concluded formally at 7:45 so as to permit a 30 minute changeover period between the two shifts, is that correct?



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A. Yes, that was flexible. What we did, and especially at Christmas time, if we were less busy by numbers, then one or two nurses would stay behind to cover the ward and the rest of the nurses were allowed to leave earlier because there was certainly times that they stayed over time.

Q. So there would have been one or two nurses then from the long day shift still on the ward if in fact his arrest was called at 7:30.

A. Yes.

Q. And in the normal course of events would I be correct in suggesting that any nurse who was assigned to long night nursing duties that evening could be expected to arrive on the ward at the earliest at approximately 7 o'clock?

A. Yes.

Q. If a nurse who had been assigned to long night nursing duties arrived on the ward one hour to 45 minutes prior to the start of her shift, would you regard that as unusual?

A. Yes.

Q. Would you regard that as particularly unusual at Christmas time, or would that have any significance one way or the other?

A. I don't know that I would give it



1
2 an awful lot of thought, it is a bit unusual, yes.

3 Q. Would it be remarked upon in your
4 judgment by the nurses who observed it?

5 A. We may make some comment, yes.

6 Q. Do you know whether or not a
7 Christmas party was in fact held on Ward 4A/4B in
8 December of 1980?

9 A. On the ward, I don't really
10 recall. I know there is a hospital Christmas party in
11 December.

12 Q. Was that held in the latter part
13 of December or the early part of December?

14 A. No, it is usually held quite a
15 bit earlier.

16 Q. And is that held on 4A/4B?

17 A. No.

18 Q. To the best of your recollection
19 today, was there a party held around Christmas time
20 on the ward 4A/4B in December, 1980?

21 A. I don't recall being invited
22 to one.

23 Q. I think I will leave that right
24 there, Mrs. Radojewski, I don't have any further
25 comments.

We have seen, quite apart from the



4 1
2 deaths that we discussed this morning that occurred
3 in July and August of 1980, that again there were a
4 number of deaths during the month of December. In
5 fact, there were five on those two wards by the end
6 of that month, and once again I take it you were aware
7 that those deaths had occurred whether or not you had
8 been on duty at the time.

9 A. Yes.

10 Q. Did you observe at that time
11 once again that many of these deaths were occurring
12 when members of the Phyllis Trayner nursing team were
13 on duty?

14 A. At around Christmas time I am
15 not sure that I recall for certain whether I knew.

16 Q. I take it that when the deaths
17 occurred at night that you would learn of those
18 deaths either from members of the long night nursing
19 staff who were leaving in the morning when you were
20 coming on work, or through the nurse who was
21 giving you reports that morning.

22 A. Yes.

23 Q. Would I be fair in suggesting
24 that it would appear by the end of December that the
25 deaths were starting again in rather larger numbers
than had been the case during the months of October



1
2 and November?

3 A. Yes.

4 Q. Did that at that time, that is
5 the beginning of January, 1981, cause you concern?

6 A. Concern in worrying about the
7 welfare of my staff again and more stress for
8 them.

9 Q. Were you not worried as well,
10 Mrs. Radojewski, that the deaths appeared to be
11 occurring in rather larger numbers than had been the
12 case in the preceding two months?

13 A. I don't recall for sure.

14 Q. Whether you were concerned or
15 not about the numbers?

16 A. I am sure I was concerned, but
17 I can't recall for certain.

18 Q. Was it a matter that you can
19 recall being discussed by you with Mary Costello?

20 A. I don't recall.

21 Q. Do you recall one way or the other
22 whether it was a matter that you raised with any of the
23 physicians on the unit, or discussed with any of the
24 members of your 4A nurses?

25 A. I can't recall in December.

Q. Do you have any recollection as to



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2 whether any of the members of the nursing staff
3 raised concerns with you regarding those deaths in
4 December?

A. I don't recall that they did.

Q. Did you towards the end of
6 December, or the beginning of January, when you had
7 been made aware that these deaths had occurred, did
8 you begin to cast around in your own mind for an
9 explanation as to why they were occurring again?

10 A. No, I don't believe that I did.

11 Q. Do you have any conscious
12 recollection today of having attempted to arrive at
13 an explanation in your own mind at that time as for
14 the deaths in December?

15 A. The explanation -- can you repeat
16 that question please?

17 Q. Yes. As you sit here today and
18 try to recall the events of early January of 1981,
19 do you have any recollection of having dealt with
20 the matter in your own mind to try and come up with
21 an explanation as to why that many children had died
22 in December?

23 A. No. I had accepted the deaths
24 of the children that had died in December, I have
25 no reason to question the numbers.



1
2 Q. You say you accepted their deaths,
3 does that fairly suggest that you mean by that that
4 you accepted the fact that they died?

5 A. Yes.

6 Q. That does not necessarily mean
7 that you accepted that there was an adequate explanation
8 for their deaths, or did you think there was?

9 A. Yes, I did.

10 Q. Did you in fact have any discussions
11 with any of the physicians to determine what
12 was the cause of death of those children who died
13 in December?

14 A. Not that I recall.

15 Q. Nor, you have told me, do you recall
16 having any discussions with any of your nurses.

17 A. I don't recall.

18 Q. We know that in early January,
19 on January 11th, another child died on the ward,
20 Janice Estrella, and she died on Ward 4A. Do you
21 recall having seen this child before she died?

22 A. Yes.

23 Q. She had been a patient for some
24 time on Ward 4A, Mrs. Radojewski. Did you, during
25 the course of your various rounds and observations of
this patient prior to her death have reason to become



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aware of what her digoxin levels were, during
life, while she was on the ward?

A. There was a period when she
first came over to 4A, specifically she was on
Ward 4B while the wards were together, and then when
4A reopened we returned her to 418 on 4A and around
that time, or after that time --

Q. Let me be clear, Mrs. Radojewski,
were you aware that during the child's life her
digoxin levels had been recorded at the hospital as
being elevated?

A. Yes, there was one point when
they were elevated.

Q. We have heard in evidence here
that her digoxin level, for example, on the 7th of
January, was greater than 9.4 nanograms; on the
8th of January it was 7.8; and on January 9th it
was 4.7. Do you have any recollection of having
known what the actual levels were that had been
recorded by the biochemistry lab at the hospital?

A. I don't recall the actual
levels, I remember the levels being up, yes.

Q. What would you regard in your
experience, Mrs. Radojewski, as a normal therapeutic
level for a digoxin reading for an infant?



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2 A. Between 1.2 to 2.1 nanograms
3 per ml.

4 Q. So that each of those on those
5 three days was considerably elevated over what you
6 would have regarded as the therapeutic norm?

7 A. Yes.

8 Q. We have heard, Mrs. Radojewski,
9 as well that a Code 23 was called for Janice Estrella
10 on January 7th, 1981 at approximately 6:55 in the
11 morning. As I understand it, you worked an 8 hour day
12 on January 7th, is that correct?

13 A. Yes, I did.

14 Q. Were you there when the Code
15 23 was called on Janice Estrella?

16 A. I don't recall being there if it
17 was called.

18 Q. If the timing be accurate, as I
19 have suggested it, about 6:55 in the morning that
20 would have occurred at or about the time when you
21 would just be arriving.

22 A. Yes.

23 Q. And if a child on your ward had
24 gone into a cardiac arrest moments before or at the
25 time that you were arriving on the ward, I take it
that that is something that would immediately be



1

2

brought to your attention?

3

A. Yes, usually I would go to
assist.

4

5

Q. But you have no recollection of
this particular child's arrest on that occasion?

6

A. No, I'm sorry, I don't.

7

8

9

Q. Do you recall any discussions
amongst any members of the nursing staff on either
Ward 4A or 4B on January 7th, or January 8th, as
to what had caused that episode to occur?

10

11

A. No, I don't recall any discussion.

12

13

14

Q. Do you recall yourself having
had any discussions with any of the physicians that
were on the ward that day as to what might have
caused that episode?

15

A. I don't recall.

16

17

18

Q. Are you aware of the fact, Mrs.
Radojewski, that following that episode on the 7th
of January digoxin was ordered held on this child?

19

A. I saw that when I reviewed the
chart, yes.

20

21

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25

Q. The evidence here has suggested
that digoxin was ordered held on January 7th and was
not reordered for the child prior to her death, does
that accord with your recollection?



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A. With my review of the chart.

3

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Q. Would you have known that at the time as the head nurse on 4A if it was a patient on your ward?

6

A. I don't recall.

7

8

9

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11

Q. I know you don't remember specifically, it is a long time ago. In the normal course of events would you expect that is a fact that you would have known at the time given your position and given the fact that she was a patient on your ward?

12

A. Yes.

13

14

15

16

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18

Q. And we have heard as well that Janice Estrella suffered a final arrest, cardiac arrest, from which she did not recover and that that occurred on January the 11th at approximately 3:30 in the morning. As I understand it, you did not work January 11th, but you did on January 12th, do I have that correctly?

19

A. Yes.

20

21

Q. Do you recall being informed of her death on the 12th of January when you came in to work?

22

23

24

25

A. I don't recall.

Q. Do you recall having had any



1
2 discussions that day with any members of the nursing
3 staff regarding the death of Janice Estrella?

4 A. No, I'm sorry, I don't recall.

5 Q. Do you recall whether or not
6 any concerns were expressed by anyone, including any
7 of the physicians who had been in attendance at
8 the time of her death, as to why the child had died?

9 A. No, I don't recall.

10 Q. Do you recall it being suggested
11 at any time, by any of the physicians on the ward,
12 or by any of the nursing staff, that digoxin
13 toxicity may have played a part in the child's
14 death?

15 A. No, I don't recall.

16 Q. We have heard in evidence from
17 Bertha Bell, who had worked on the long night shift
18 the night of Janice Estrella's death, that Dr. Schaffer
19 suggested to a number of nurses who had been on duty
20 that night, after the child had died, that digoxin
21 toxicity may have contributed to her death. Was
22 that a matter that was ever the subject of discussion
23 between Bertha Bell and yourself?

24 A. Not that I recall.

25 Q. Do you recall any discussions
which you participated with Dr. Schaffer regarding



1

2

the matter?

3

A. No, I don't recall.

4

5

Q. Were you informed after her death that a post mortem digoxin test had been ordered on Janice Estrella?

6

7

THE COMMISSIONER: You want to refine that a little more, don't you?

8

9

MS. CRONK: I will come to the matter of the sample itself, sir, in a moment.

10

THE COMMISSIONER: No, I meant, when.

11

12

13

Q. I'm sorry, immediately after her death, when you learned that she had died, were you told that the post mortem test had been ordered for digoxin?

14

A. No.

15

16

Q. Do you recall when you learned that for the first time?

17

18

A. I believe that was later on in March.

19

Q. Do you recall when in March?

20

A. When I met with Sergeant Warr, March 23rd.

21

22

Q. After the death of Justin Cook, on the Monday?

23

A. Yes.

24

25



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Q. You were told at that time that
a test had been done?

3

4

A. Yes.

5

6

Q. Were you told what the actual
levels were that had been recorded for Janice
Estrella?

7

8

A. I don't recall.

9

10

11

12

13

14

Q. Prior to that meeting, and I am
not going to ask you any questions with respect
to generally what happened at that meeting, but
prior to the meeting with Sergeant Warr on Monday,
March 23rd, had you been made aware by anyone that
Janice Estrella's digoxin levels taken after she
had died were elevated?

15

A. I don't recall.

16

17

Q. You don't remember whether that
was the first time you learned of that or not?

18

19

20

A. That's right.

Q. When did you learn for the first
time what the actual level was on the post mortem
samples taken from Janice Estrella?

21

22

A. I'm sorry, I don't recall when
I actually learned that.

23

24

25

Q. And I ask you to listen to the
next question or two, if you would, Mrs. Radojewski,



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very carefully and see if you can in your own mind
recall the events that occurred. Did you at some
point after Janice Estrella's death discuss her
death with Dr. Freedom?

A. Yes, I may have.



BmB.jc
DD

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Q. Do you recall whether or not it was during the occasion of that discussion that you learned what the actual levels were on Janice Estrella, her digoxin readings?

6

A. He may have told me, I don't recall for sure.

7

8

9

Q. All right. Mrs. Radojewski, do you recall being interviewed by the staff of this Commission in preparation for your giving evidence here?

10

A. Yes.

11

12

Q. Do you recall being interviewed on the Wednesday night, February 22nd and Thursday, February 23rd for that purpose?

13

A. Yes.

14

15

Q. Last week?

16

17

18

19

Q. Do you recall as well having told Commission staff at that time that you learned of Janice Estrella's actual post mortem digoxin levels for the first time in a discussion with Dr. Freedom? Do you recall having said that?

20

21

22

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25

A. Yes.

Q. All right.

Q. Do you recall when that discussion took place, was it before or after Susan



DD.2

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Nelles had been arrested for the murder of Justin Cook?

3

I am asking you now simply the time of the meeting.

4

A. I don't recall at this time.

5

Q. All right. Well again,

6

Mrs. Radojewski, to help you with that, during the course of the same meeting with Commission staff do you recall being asked the same question?

8

A. I'm sure I was.

9

Q. All right. Do you recall

10

telling Commission staff at that time that that

11

discussion with Dr. Freedom took place after Susan

12

Nelles had been charged with the murder of Justin Cook?

13

THE COMMISSIONER: That being the case I don't know why you pursued it.

14

15

MS. CRONK: I would just like to be certain if we could to establish today, sir, when

16

it was that Mrs. Radojewski knew the actual digoxin

17

levels and it seems that today her recollection is

18

less clear than perhaps it was previously.

19

Q. You don't recall that I take it either?

20

21

MR. ROLAND: Sir, I am not objecting to it but I am greatly relieved of the answer from Commission counsel.

22

23

THE COMMISSIONER: Yes, yes.

24

25



DD.3

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MS. CRONK: Q. You don't recall that discussion either?

4

A. Yes, I do recall the discussion with you.

5

Q. Yes.

6

A. Yes.

7

8

9

10

Q. All right. Do you recall at any time, apart from the discussion that you had with Dr. Freedom, do you recall at any time following the death of Janice Estrella it being suggested to you that her death had been reported to the coroner?

11

A. I don't recall.

12

13

14

15

Q. All right. Looking back to the time in January and the days following her death, do you remember it being suggested that her death in fact had been reported to the coroner by Dr. Schaffer?

16

A. Could you repeat that, please?

17

18

19

20

Q. All right. Looking back to the time in January of 1981 after the child had died, do you remember it ever being suggested to you at that time that her death had been reported to the coroner by Dr. Schaffer?

21

A. No, I don't recall.

22

23

24

25

Q. That was not a matter that you can recall having been brought to your attention by



DD. 4

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any members of the 4A nursing staff?

3

A. That's right.

4

Q. You have told us earlier in the

5

day, Mrs. Radojewski, that you attended the two

6

mortality meetings held in September at the Hospital.

7

It is the evidence before the Commissioner there was

8

a third meeting held on January 12th, 1981. Did you

9

attend that as well?

10

A. Yes.

11

Q. Mr. Registrar, could you show

12

Mrs. Radojewski if you would please Exhibit 65, which
are the minutes of that meeting.

13

It is my understanding, Mrs. Radojewski,

14

that the death of some 20 children were reviewed at
this meeting, as is reflected by the minutes.

15

According to the attachments to the minutes which

16

have been filed as an exhibit here, Janice Estrella

17

was not amongst those children that were discussed.

18

Do you have any recollection today of Janice Estrella's

19

death being raised for discussion at that meeting

20

on January 12th?

21

A. I have no recollection of her

22

death being raised at that meeting.

23

Q. What was the focus of the

24

meeting as you understood it?

25



DD.5

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A. The impression I was left with at the end of the meeting is the thrust for an intermediate ICU on either Ward 4A or 4B.

Q. Were you there for the entire meeting?

A. Yes.

Q. Did you keep any notes of that meeting?

A. I may have, I don't have them if I did.

Q. Do you recall anyone at that meeting suggesting in relation to any of the 20 children whose deaths were reviewed and discussed at the meeting that digoxin toxicity may have played a part in any of their deaths?

A. No, I don't recall any such discussion.

Q. Was it phased in - well, to assist you, if you look to the schedule attached to the minutes of the meeting, the first page of the schedule, you will see the names of various children. Amongst them are David Taylor, Amber Dawson, D'Arcy MacDonald and Richard McKeil. In particular, do you remember anyone at that meeting raising the issue of digoxin in any context with respect to



DD.6

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2

the deaths of any of those four children?

3

A. I don't recall.

4

5

Q. Was there any discussion at the meeting on January 12th insofar as you can recall regarding the fact that many of these 20 deaths had occurred on the long night nursing shift?

6

7

A. No, not that I recall.

8

9

Q. Was that a matter that you raised at the meeting?

10

A. I don't remember raising it.

11

12

Q. Do you recall any discussion at that meeting concerning the fact that many of these 20 deaths had occurred when members of the same nursing team were on duty?

13

14

A. Could you repeat the first part of that, please?

15

16

17

Q. Yes. Do you remember any discussion at the meeting of January 12th as to the fact that many of those 20 deaths had occurred in the presence of one nursing team on Ward 4A?

18

19

20

A. No, I don't remember any discussions.

21

22

Q. Did you raise that issue?

23

A. No, I didn't.

24

Q. All right. When we move to

25



DD.7

1
2 February of 1981 there are three deaths; in
3 particular, the first Frank Fazio, that I would like
4 to discuss with you. That child died on February 4th
5 again during the long night shift at approximately
6 4:45 in the morning. He was a patient as I understand
7 it on Ward 4A?

8 A. Yes.

9 Q. It is my understanding that
10 you worked an 8-hour day shift on February 3rd and
11 again on February 4th, that is, the day after his
12 death. Do I have that correctly?

13 A. Yes.

14 Q. Do you recall having seen the
15 child at any time on February 3rd prior to his death?

16 A. I know I must have seen him,
17 I don't recall anything specific on the 3rd.

18 Q. All right. Could I ask to
19 assist you in that regard, turn to the tour end
20 reports, Mrs. Radojewski, page 99. Could we start
21 first please with the notes recorded on the tour end
22 report for February 2nd. I draw your attention to
23 the notes made for the day shift, the 8-hour day
24 shift. Are they yours?

25 A. Yes.

Q. Is there anything in those



DD.8

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notes now, now that you have the opportunity to review them, which suggest to you that as of the end of that day when you left work the child was in grave condition or considered to be very seriously ill?

A. No.

Q. As he was transferred from the Intensive Care Unit at 11:30 that day on February 2nd, I take it he would automatically have been included in the tour end report for February 2nd?

A. Yes.

Q. And he was not on either shared nursing care nor constant care that day?

A. No, not that I can see.

Q. And then we come to February 3rd, the very next day, and again he does not appear to be on shared care nursing nor constant care nursing?

A. Right.

Q. And once again are the day shift entries for February 3rd yours?

A. Yes.

Q. And in the description contained of his condition set out in the tour end report, would you regard that as being a description of a gravely ill child at that stage?

A. No.



DD.9

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2

A. No.

3

Q. Is there anything in the

4

entries for the evening shift as distinct from the
5 long night shift or in the daytime entries which you
yourself made which suggest that he was at imminent
6 risk of dying?

7

8

A. He was at risk by virtue of
the sepsis diagnosis and his heart rate was up, but
9 not, I wouldn't say, of dying.

10

11

Q. All right. And when you left
on February 3rd having completed your shift to the
12 best of your recollection, was he then in the process
of dying?

13

14

A. Not that I recall.

15

16

Q. Do you remember one way or the
other whether or not you had any concerns that he
might die that very night?

17

A. I don't recall.

18

19

Q. Do you recall any discussions
following his death with any members of your
nursing staff as to why he had died?

20

21

A. No, I don't recall.

22

23

Q. Do you recall concerns being
raised in that regard by anyone connected with the
Cardiology Unit insofar as you were aware?

24

25



DD.10

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A. I don't recall any concerns
being raised.

4

5

MS. CRONK: Sir, may we take our
break now then, I am moving to another child?

6

7

THE COMMISSIONER: Yes, all right,
twenty minutes.

8

--- Short recess.

9

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EE/EMT/ko 2

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--- On resuming

3 THE COMMISSIONER: I am getting a
4 little bit alarmed - I am alarmed about the weather
5 but that is not what I am thinking of. This 9:30
6 party tomorrow is getting bigger and bigger.

7 MS. CRONK: I see.

8 THE COMMISSIONER: And where is
Mr. Young?

9 MS. CRONK: I am sorry, sir. He may
10 be in the hall. Shall I get Anita to see if he is
11 there? We will just see if he is in the hall.

12 THE COMMISSIONER: You carry on and
13 when he comes we will just interrupt.

14 MS. CRONK: Fine, sir.

15 THE COMMISSIONER: Yes, now, Mr. Young,
16 to betray some confidences, at this meeting that was
17 scheduled for tomorrow (just you and then just
18 Miss McIntyre) has got bigger and bigger and I don't
19 really see how we can have it without inviting every-
20 body to it. Do you still want it under those
circumstances?

21 MR. YOUNG: Sir, I don't see much
22 point. Might I suggest that tomorrow morning first
23 thing we examine the issues that I suggested may be
24 in question.
25



EE 2

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THE COMMISSIONER: At 10 o'clock.

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MR. YOUNG: At 10 o'clock, and we do
it publicly here.

5

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THE COMMISSIONER: All right. That I
think is a solution. The party is off.

7

8

MS. CRONK: Well, for the benefit, sir,
of those who have no idea what is presently being
discussed --

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THE COMMISSIONER: It is a question as
to what is the definition of Phase 1 and what is Phase
2, that is all. It is a matter really of major
concern - my only excuse for having a private party
with Mr. Young and Miss McIntyre was it seemed to
concern them more than anyone else. But the more I
think of it the more it concerns everybody, so we will
do it at 10 o'clock tomorrow morning. If we are not
snowbound.

17

18

MR. YOUNG: Might I just say the reason
we asked for the meeting was simply to save time.

19

20

THE COMMISSIONER: Absolutely. There
is no question about it.

21

22

MR. YOUNG: We weren't trying to hide
anything.

23

24

25

THE COMMISSIONER: No. I am entirely
with you. It was just so that you would know what was



1
2 a fair field for cross-examination and what was not.

3 MR. YOUNG: Thank you, sir.

4 THE COMMISSIONER: We will see if we
5 can do it at 10 o'clock, and if we can, that is all
6 to the good, and if not we will just have to take it
7 as it comes up.

8 MS. CRONK: Thank you, sir.

9 THE COMMISSIONER: All right now.

10 MS. CRONK: Sir, I am conscious both
11 of the weather and the time, and it has been suggested
12 by some Counsel I think appropriately that perhaps we
13 should adjourn somewhat earlier today.

14 THE COMMISSIONER: Yes.

15 MS. CRONK: Because the weather
16 conditions are deteriorating.

17 THE COMMISSIONER: Yes.

18 MS. CRONK: I am in your hands, sir.
19 I can deal with another child now which will take me
20 until slightly after 4 o'clock.

21 THE COMMISSIONER: One more child will
22 take you until after 4 o'clock?

23 MS. CRONK: Yes, sir, it will. You
24 took three of my minutes, sir. I have been counting.
25 That is 12 questions at least.

THE COMMISSIONER: Well, maybe we had



EE 4

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better not. Maybe we had better break off now until
10 o'clock tomorrow morning.

3

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How long do you think you will be
tomorrow?

5

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MS. CRONK: Unfortunately the better
part of the morning, sir.

7

8

THE COMMISSIONER: Yes, all right.

9

10

Do you have any idea, Miss McIntyre?
I suppose it will depend upon what is legitimately
Phase 1.

11

12

MS. McINTYRE: That is correct, sir,
but I would anticipate being several hours with this
witness.

13

14

THE COMMISSIONER: Well, there you are.
All right. Until tomorrow at 10 o'clock.

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--- Whereupon the hearing adjourned at 3:45 p.m.
until Tuesday, February 29th, 1984 at 10:00 a.m.

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